APEX
PHYSICAL THERAPY AND FITNESS

REGISTRATION FORMS

PATIENT INFORMATION:

First Name: _____Middle:___ Last: _____Birth Date ___/___/___
Address: _____ City: _____State: ___ Zip: _____Age: _____
Social Security Number _____-_____-_____ Sex: ___ Male ___ Female
How did you hear of us? Doctor____ Insurance____ Family/Friend:_____
Are you employed? ___ Yes ___ No ___ Occupation: _____
Are you disabled? ___No ___Yes: If so, Reason: _____
Primary Care Doctors Name:_____ Phone #:_____
Specialist (if applicable):_____ Phone #:_____

CONTACT INFORMATION:

Home #:_____ Work #: _____ EXT. _____
Cell #:_____ Email: _____
My preferred method to reach me during the day is: home /cell /work /email
In case of emergency, contact:
Name: _____ Relationship: _____
Home #: _____ Work#:_____ Cell#:_____

CANCELLATION/NO SHOW POLICY:

If you do not provide 24 hours notice to cancel an appointment, or you do not attend a scheduled appointment, you will be charged a no-show/cancellation fee of $50.00.
We will not impose this fee with weather related cancellations.

ASSIGNMENT OF BENEFITS:

I authorize Apex Physical Therapy & Fitness, Inc. to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
I authorize release of any information related to any claims to all my insurance companies or other relevant parties.
I understand that I am individually responsible for my bill and agree to pay all charges for services and items provided to me as well as attorneys fees incurred by Apex Physical Therapy and Fitness in the collection of charges and services. If I am unable to execute this form then the guardian/attorney-in-fact acting on my behalf is responsible for the same obligation
I understand that I am individually responsible to pay co pays or deductibles. If I am unable to execute this form then the guardian/attorney-in-fact acting on my behalf is responsible for the same obligation
I authorize payment of health benefits otherwise payable to me, directly to Apex Physical Therapy & Fitness, Inc.
I permit a copy of this authorization to be used in place of the original.
This "Signature on File" is valid for one year from the date indicated below.

_____ _____
Signature of Patient, Beneficiary or Guardian Date

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AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of information during the course of my treatment at Apex Physical Therapy & Fitness, Inc. including but not limited to medical records, verbal and written communications to my insurance company, doctors, and third party payers.

I have received and read a copy of Apex Physical Therapy & Fitness, Inc.'s privacy procedures.

_____ _____

Patient Signature or Legal Guardian Date

We thank you for filling out this form completely. The therapist will review this information at your appointment and you will have the opportunity to discuss any questions, concerns or clarifications.

CURRENT COMPLAINT:

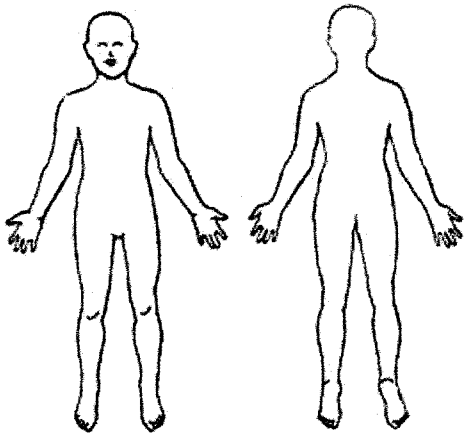
When did your injury occur? _____/_____/_____

What is your main complaint? _____

_____

_____

Using the body diagram below please mark the areas where you are having problems:



Please rate your pain on the scale from 1-10, circle one number below that describes your pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

Has this or something similar happened in the past? ____ Yes ____ No

If yes, explain past episodes:

_____

_____

_____

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GENERAL HEALTH INFORMATION:

What is the date of your last physical? _____
Do you smoke? ___ Yes ___ No
Do you exercise beyond normal daily activities and chores? ____ Yes ____ No
If so, what: _____

MEDICAL HISTORY:

Please check (___) if you have or had any of these medical issues:

___ Heart Attack
___ Heart problems/disease
___ Cancer
___ High cholesterol
___ Osteoporosis
___ Lung problems
___ Head injury
___ Seizures/epilepsy
___ Ulcers/stomach problems
___ Artificial Bones Joints
___ Angina
___ Migraines
___ High blood pressure
___ Psychological Disorder
___ Broken bones/fractures
___ Diabetes/high sugar
___ Multiple sclerosis
___ Skin diseases/problems
___ Asthma
___ Developmental or growth problems
___ Heart murmur
___ Stroke
___ Circulation problems
___ Arthritis
___ Blood Disorders/Anemia
___ Hypoglycemia/low sugar
___ Muscular dystrophy
___ Depression
___ Pacemaker

If you checked yes to any of the above, please explain:

_____
_____
_____
_____
_____
_____

SURGERIES:

Please list all past surgeries and the date of surgery:

_____
_____
_____
_____
_____

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SYMPTOMS:

Please check if you have had any of the following symptoms in the past year:
Check all that apply

___ Chest pain
___ Shortness of breath
___ Excessive Weakness
___ Joint pain or swelling
___ Loss of appetite
___ Vision Problem
___ Fever/chills/sweats
___ Heart palpitations
___ Dizziness/LOC
___ Loss of balance
___ Pain at night
___ Nausea/vomiting
___ Weight loss/gain
___ Headaches
___ Cough hoarseness
___ Coordination problems
___ Difficulty walking
___ Difficulty sleeping
___ Difficulty swallowing
___ Hearing problems
___ Bowel problems (constipation/loss of control)
___ Urinary problems (leakage/retention)

Other:_____

_____

OTHER CLINICAL TESTS:

Please check if you have had any of the following for your current issue:

___ CT Scan/CAT Scan
___ EKG (electrocardiogram)
___ Myelogram
___ Ultrasound
___ MRI
___ Nerve Conduction Velocity
___ EEG (electroencephalogram)
___ EMG (electromyogram)
___ X-Rays

_____

MEDICATIONS:

*Please list all of the medications and amounts that you are taking (over the counter and prescribed):

_____
_____
_____
_____
_____

SIGNATURE:

I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. I hereby give my consent for physical therapy treatment and services at Apex Physical Therapy & Fitness, Inc.

Patient's or Legal Guardian's Name: _____
(Please Print)

Patient's or Legal Guardian's Signature: _____

Date: _____

APEX
PHYSICAL THERAPY AND FITNESS

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

* You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

* We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

* You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

* We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

* You can ask us to contact you in a specific way (*for example, home or office phone or to send mail to a different address).*

* We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

* You can ask us not to use or share certain health information for treatment, payment, or our operations.

    * We are not required to agree to your request, and we may say "no" if it would affect your care.

* If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with health insurer.

* We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shares information

* You can ask for a list (accounting) of the items we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

* We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will change a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

* You can ask for a copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

* We will make sure the person has the authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

* You can complain if you feel we have violated your rights by contacting Apex at 603-249-3337.

* You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S. W., Washington, D.C. 20201, calling 1-877-696-6775, or visit www.hhs.gov/ocr/privacy/hipaa/complaints/

* We will not retaliate against you for filing a complaint.

Your Choice

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In this case, you have both the right and choice to tell us to:

* Share information with family, close friends, or others involved in your care.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

* Marketing Purposes

* Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information

We typically use or share our health information in the following ways:

Treat you

* We can use your health information and share it with other professional who are treating you.

Example: a doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

*We can use and share your health information to run our organization, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

* We can use and share your information to bill and get payment from your health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/noticepp.html.

Help with public health and safety issues

* We can share health information about you for certain situations such as:
    * Reporting adverse reaction to medications to your provider
    * Reporting suspected abuse, neglect, or domestic violence
    * Preventing or reducing a serious threat to anyone's health or safety

Do research

* We can use or share your information for health research.

Comply with the law

* We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to lawsuits and legal actions

* We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Addressing worker's compensation, law enforcement, and other government requests

* We can use or share health information about you:
    * For workers' compensation claims
    * For law enforcement purposes or with a law enforcement official
    * For special government functions such as military, national security, and presidential protective services

Our Responsibilities

* We are required by law to maintain the privacy and security of your protected health information.

* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

* We must follow the duties and privacy practices described in this notice and give you a copy of it.

* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/noticepp.html.

Changes to Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Apex Physical Therapy & Fitness
199 State Route 101 Suite 5B
PO Box 253
Amherst, NH 03031
ApexPTHN.com

Original: 2019

Health Insurance Portability and Accountability Act (HIPAA)

Apex Physical Therapy & Fitness, Inc.
Notice of Privacy Practices

Acknowledgement

I have obtained the Notice of Privacy Practices and have had the opportunity to review it.

Patient's or Legal Guardian's Name:_____
(Please Print)

Patient's or Legal Guardian's Signature:_____

Date:_____

This notice is effective on or after January 1, 2014

A copy of this notice is available upon request.