NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND YOUR ABILITY ACCESS YOUR INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Your confidential medical information is defined under federal law as "protected health information" ("PHI"). When we retain your confidential medical information on its computer system, it is called "electronic protected health information" ("ePHI"). This Notice applies to all PHI and ePHI related to your care that we have created or received. It also applies to any personal or general information we receive from patients, including information contained on driver's licenses. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

USE AND DISCLOSURE WITHOUT PATIENT ACKNOWLEDGEMENT OF THIS NOTICE

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your Care.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, precertification and preauthorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations,including improvement in our methods of operation, and general administrative

functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

USE AND DISCLOSURE WITHOUT ACKNOWLEDGEMENT OR AUTHORIZATION

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization.Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status.We are also required to report instances of suspected or documented abuse, neglect or domestic violence.We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity.We must also provide medical record information when ordered by a court of law to do so.

AUTHORIZATION FOR USE OR DISCLOSURE

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time.In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse,HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records without your specific written consent and authorization. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization. Your medical information will not be disclosed for marketing purposes or sold to any third party without your authorization. Other uses and disclosures of your medical record information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to “take back” any disclosures that we have already made with your permission and that we are required to keep any records of the care that we provided to you.

Additional Uses and Disclosures

Advice of Appointment and Services: The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may interest you.The following appointment reminders may

be used by the Practice: a) postcard mailed to you at your address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

Individual Rights

You have certain rights with respect to your medical record information, as follows:

1.You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; howe ver, if we agree, we will comply with it,except with respect to emergencies,disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2.You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services out of your own pocket, in full.This does not apply to services that are covered by insurance.You are required to pay cash, in full, for the services before the restriction applies.

3.With respect to ePHI, we agree to give you your ePHI in the form and format requested by you, if it is readily producible in that form or format. If it is not readily producible in the form or format requested, we will give you a readable hard copy form. Any directive given to us by you to transmit ePHI must be done in writing by you, signed and clearly identify the designated person and location to send the ePHI. We will provide you access to your PHI or ePHI within thirty (30) days from the date of request.

4. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

5. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise Restricted by law. We will charge a reasonable fee for providing a copy of your medical records,or a summary of those records,at your request,which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

6. We may deny any request for amendment of your PHI or ePHI if the information was not created by us (unless the originator of the information is no longer available to act on your request); is not part of the designated record set maintained by us; is not part of the information to which you have a right of access; or is already accurate and complete, as determined by us. If we deny your request for an amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

7. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to “Privacy Officer” at our address. We will respond to your request in a timely fashion.

8. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting In an 12-the period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.

9. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.

10. All requests related to your rights herein must be made in writing and addressed to “Privacy Officer” at the address noted below.

11. You have the right to receive notification from us if any breach of your unsecured protected health information occurs.

Our Duties

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information In your medical records and to provide you with this Notice of its legal duties and Privacy practices with respect to that information.

2.We are required to abide by the terms of this Notice currently in effect.

3. We reserve the right to change the terms of this Notice at anytime, making then new provisions effective for all health information and medical records we have and
Continue to maintain. All changes in this Notice will be prominently displayed and
Available at our office.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we
cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints online at the government's
Website: http://www.hhs.gov/ocr/hipaa.

This Notice of Privacy Practices shall not be construed as a contract or legally binding agreement. Any non-compliance with any provision of this Notice shall not be construed as a breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law. By signing the Acknowledgment of Receipt of this Notice, you agree that the sole legal recourse for our non-compliance with this Notice is to file a written complaint to the Secretary of the U.S. Department of Health and Human Services, and that no complaint or cause of action may be filed in any federal or state court for breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law, or under any tort theory.

Contact Person

All questions concerning this Notice, or requests made pursuant to it, should be addressed to:
Selena Siplin (Director of Operations)

Effective Date *This Notice is effective April 14, 2003 and revised August 24,2017 and applies to All protected health information contained in your medical records maintained by us.*

Appendix F
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

As part of my health care, **One on One Physical Therapy Physical Therapy** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnosis and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the *Notice of Privacy Practices.*

I acknowledge that I have received a copy of the *Notice of Privacy Practices of One on One Physical Therapy* and agree to the liability limitations explained therein.

_____	_____
Signature of patient or legal representative	Relationship to patient
_____	_____
Printed name of patient	Date

PATIENT INFORMATION CONSENT FORM

I have read and fully understand One-on-One Therapy's Notice of Information Practices. I understand that One-on-One Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the One-on-One Therapy in writing. I also understand that One-on-One Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in One-on-One Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying One-on-One Therapy in writing at any time.

Signature:_____ Date:_____

PATIENT PRIVACY NOTICE

HIPPA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers.
- Healthcare Transaction & Code Sets for transmitting date electronically.
- Privacy regulations over disclosure and use of health information.
- Security regulations over protections of electronic health information.

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number if not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to
have information released to someone other than yourself please complete the following:

I, _____, hereby authorize One-on-One Therapy's staff to leave medical information pertaining to my care by telephone, email or voicemail and will assume responsibility to notify them whenever this information changes.

Signature:_____ Date:_____

CONSENT TO TREATMENT

I do hereby consent to such treatment by the authorized personnel of One-on-One Therapy as may be dictated by prudent medical practice by my illness, injury or condition. This is intended as a waiver of liability for such treatment excepting acts of negligence.

Signature: _____ Date:_____

PATIENT INFORMATION FORM

Today's Date:_____Date of Injury:_____ State Where Injury Occurred:_____

Condition Related To:

☐ Fall ☐ Auto accident ☐ Surgery

☐ Sports Injury ☐ Employment Injury ☐ Other:_____

Patient's Name:_____ Sex:___ D.O.B.:_____ Age:_____

Address:_____ City:_____

State:_____ Zip Code:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____ Email:_____

Emergency Contact Name::_____ Emergency Contact Phone:_____

Referral Source:

☐ Website ☐ Social Media ☐ Friend ☐ Employer ☐ Attorney ☐ Physician ☐ Other

Referring Physician:_____ Phone:_____Fax:_____

Address:_____City:_____ State:_____ Zip Code:_____

METHOD OF PAYMENT

☐ Cash ☐ Check Credit ☐ Card

I hereby authorize One-on-One Therapy to furnish information which may be required to process insurance claims for payment of medical services for myself and/or my dependents.

Signature of Responsible Party:_____Date:_____

One-on-One Therapy strives to provide the highest quality patient care. Patients receive physical therapy treatment without other patients present for each visit.

As health care costs continue to rise, One-on-One Therapy makes every effort to maintain our standards of care. In order to honor this commitment, we are an out-of-network provider.

As a courtesy, One-on-One Therapy will file the patient's claim with their insurance provider. The patient is responsible to pay the full amount due at the time of service. As a courtesy, One-on-One will file a claim with the patient's insurance provider and they will be reimbursed according to their plan. The the patient will be held responsible for any uncovered amounts.

Please call our billing department for questions regarding any bills you receive.If this is a workers compensation case, we will bill your worker's compensation carrier for your charges.

Case History

Name_____ **Age**_____ **Today's Date**_____

Ht_____ **Wt**_____ **BP(Blood Pressure)**_____ **PCP**_____

History of Present Condition:_____

_____

Date of Surgery, (if any) for this problem:_____

Primary/Current Complaint(s)_____

_____

How long have you had your symptoms? Days: _____ Months:_____ Weeks:_____

Date of Onset:_____

Was the onset of your symptoms due to any of the following? (check all that apply)

What was the onset speed of your injury?

☐ Chronic Symptoms ☐ Motor Vehicle Accident ☐ Sports/Recreational Activity

☐ Work Related Injury ☐ Unknown Onset ☐ Overuse ☐ Trauma ☐ Other _____

☐ Gradual ☐ Insidious ☐ Sudden

Describe your recent symptom trend? ☐ Improving ☐ Unchanged ☐ Worsening

Previous Functional Level

☐ No limits with activities of daily living ☐ No limits with work activities

☐ No limits with recreational activities ☐ Other_____

ACTIVITY MEASURES

Please indicate if any of the following activities aggravate your symptoms:

Activity	Symptoms	After how long
Ascending Stairs	☐ Yes ☐ No	_____
Bathing	☐ Yes ☐ No	_____
Carrying up to 25 lbs.	☐ Yes ☐ No	_____
Childcare	☐ Yes ☐ No	_____
Defecation	☐ Yes ☐ No	_____
Descending Stairs	☐ Yes ☐ No	_____
Desk work/Computer Use	☐ Yes ☐ No	_____
Dressing	☐ Yes ☐ No	_____
Driving	☐ Yes ☐ No	_____
Exercise	☐ Yes ☐ No	_____
Grooming	☐ Yes ☐ No	_____
Housework	☐ Yes ☐ No	_____
Kneeling	☐ Yes ☐ No	_____
Lifting more than 25 lbs.	☐ Yes ☐ No	_____
Lifting up to 25 lbs.	☐ Yes ☐ No	_____
Reaching across	☐ Yes ☐ No	_____
Reaching back	☐ Yes ☐ No	_____
Reaching out	☐ Yes ☐ No	_____
Reaching up	☐ Yes ☐ No	_____
Running	☐ Yes ☐ No	_____
Sexual Intercourse	☐ Yes ☐ No	_____
Sitting	☐ Yes ☐ No	_____
Sleeping	☐ Yes ☐ No	_____
Sport Activity	☐ Yes ☐ No	_____
Squatting	☐ Yes ☐ No	_____
Standing	☐ Yes ☐ No	_____
Urination	☐ Yes ☐ No	_____
Walking	☐ Yes ☐ No	_____

Work Activity ☐ Yes ☐ No _____

Yardwork ☐ Yes ☐ No _____

What are your goals/reason for treatment? _____

_____

_____

What activities do you want to return to? _____

_____

Can you localize your pain? ☐ Yes ☐ No

If yes, where is your pain?_____

PAIN SCALE: (Use the scale to the left to rate your pain)

At best?_____ At worst?_____

0 No Pain
1 Mild: you are aware of it, but it doesn't bother you
2 Mild:you become more aware of it,but only begins to bother you
3 Moderate that you can tolerate without medication
4 More severe pain that requires medication to tolerate
5 Severe Pain: you begin to feel antisocial
6 Severe Pain: you cannot participate in recreational activities
7 Very Severe Pain: you cannot participate in activities of daily living
8 Intensely Severe Pain: you cannot leave the house
9 Extremely Severe Pain: you cannot get out of bed
10 Most Severe Pain: it may make you contemplate suicide

What is the quality of your pain? (check all that apply)

☐ **Dull** ☐ **Numbness** ☐ **Pins and Needles** ☐ **Pulsating**

☐ **Radiating** ☐ **Sharp** ☐ **Steady** ☐ **Throbbing**

Is your pain dependent on the time of day? ☐ Yes ☐ No
If yes, what time(s) is better?_____
What time is worse?_____

Rate the frequency of your pain?

☐ **Constant** ☐ **Intermittent/daily**

☐ **Occasional (less than daily)** ☐ **Sporadic (less than weekly)**

For the following activities, check the box next to those that AGGRAVATE your symptoms.

☐ **Modifying your activities** ☐ **Cessation of activity** ☐ **Lying down** ☐ **Medication**

☐ **Standing** ☐ **Heat** ☐ **Ice** ☐ **Rest** ☐ **Sitting** ☐ **Walking**

For the following activities, check the box next to those that RELIEVE your symptoms.

☐ **Modifying your activities** ☐ **Cessation of activity** ☐ **Lying down** ☐ **Medication**

☐ **Standing** ☐ **Heat** ☐ **Ice** ☐ **Rest** ☐ **Sitting** ☐ **Walking**

Prior Episodes

Have you had prior episodes of this condition? ☐ Yes ☐ No

If yes please answer the following:

How many prior episodes? ☐ 1-5 ☐ 6-10 ☐ 11+ Year of first episode?

Is the Severity ☐ Increasing ☐ Decreasing ☐ Unchanged

Which treatments have you had for THIS condition?

☐ Acupuncture ☐ Chiropractic ☐ Massage Therapy ☐ Physical Therapy

☐ Other ☐ Bed rest ☐ Injection ☐ Medication ☐ Surgery

Lifestyle

Which best describes your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you consider yourself generally? ☐ Sedentary ☐ Physically Active

What is your current exercise routine?_____

What is your occupation?_____

What is your work status?

☐ Full time ☐ Part time ☐ Retired ☐ Unemployed
☐ Regular Duty ☐ Restricted Duty ☐ Other

Fall History

Injury as a result of a fall in the past year? ☐ Yes ☐ No If yes, date of fall:_____

Two or more falls in the last year? ☐ Yes ☐ No If yes, dates of falls:_____

Medical History

Please check the box next to each pre existing or previous condition.

Allergies ☐	Bowel Incontinence ☐	Constipation ☐
Anemia ☐	Cancer ☐	Currently Pregnant ☐
Anxiety ☐	Cardiac Conditions ☐	Depression ☐
Arthritis ☐	Cardiac Pacemaker ☐	Diabetes ☐
Asthma ☐	Chemical Dependency ☐	Difficulty Breathing ☐
Bladder Incontinence ☐	Circulation Problems ☐	Dizzy Spells ☐
Endometriosis ☐	Metal Plants ☐	Straining with Urination ☐
Fractures ☐	Multiple Sclerosis ☐	Strokes ☐
Gallbladder Problems ☐	Osteoporosis ☐	Thyroid Disease ☐
Gynecological Problems ☐	Parkinsons ☐	Tuberculosis ☐
Hepatitis ☐	Painful Periods ☐	Urgency with Urination ☐
High Blood Pressure ☐	Prostatitis ☐	Vision Problems ☐

HIV ☐	Recent Fever ☐	Weight Loss ☐
Incontinence ☐	Rheumatoid Arthritis ☐	Weight Loss ☐
Kidney Problems ☐	Seizures ☐	Straining with Urination ☐

Women: # of Pregnancies _____ # of Children _____

In the past month have you experienced:

☐ Night Pain ☐ Night Sweats ☐ Unresolved Fever ☐ Nausea
☐ Loss of Consciousness ☐ Unexplained Weight loss or gain?

Describe any other conditions or precautions:_____
_____

During the last month have you experienced feeling depressed or hopeless? ☐ Yes ☐ No

During the last month have you had little interest or pleasure in doing things? ☐ Yes ☐ No

Is this something for which you would like help with? ☐ Yes ☐ Yes, but not today ☐ No

Surgery History

Body Region: _____ Surgery Type: _____ Date of Surgery:_____
Body Region: _____ Surgery Type: _____ Date of Surgery:_____
Body Region: _____ Surgery Type: _____ Date of Surgery:_____

Have you undergone any of the following diagnostic testing? ☐ Yes ☐ No

Results from above tests:_____

Current Medications

Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____

Next Physician Visit?_____

How did you hear about us? _____

Patient Name:_____ **Date:**_____

The Patient--Specific Functional Scale

Instructions: Think of activities that you are unable to do or are having difficulty doing as a result of your injury or problem. On the items below, write the name of the activity or activities And give each a rating from 0 to 10 based on your perceived ability to perform them at this time.

Activity#1:_____
0 1 2 3 4 5 6 7 8 9 10
Unable Able to perform(preinjury level)

Activity #2:_____
0 1 2 3 4 5 6 7 8 9 10
Unable Able to perform(preinjury level)

Activity#3:_____
0 1 2 3 4 5 6 7 8 9 10
Unable Able to perform(preinjury level)

Activity#4:_____

0 1 2 3 4 5 6 7 8 9 10
Unable Able to perform(preinjury level)

Liability Waiver

Full Name:_____

I, _____, understand that any physical activity program I undertake must be pre-approved by my personal physician. I understand that any time I enter into a location devoted to physical fitness, or participate in physical activity, that I may be injured and that the injury may be catastrophic. With full understanding of the potential catastrophic injuries I may sustain by participating in any physical activity, including but not limited to, physical weights, cardio and aerobic training, physical therapy, massage therapy, strength training, and other activity, including self-directed activities (collectively referred to as “Activities”), taking place at Equipoise, LLC which is located at 3300 Northeast Parkway, Building 8, Suite A, Atlanta, GA 30341 (“Equipoise”), I hereby release to the fullest extent allowed by law: Equipoise, LLC, Davis Fox Group, LLC and all of their employees, members, owners, and operators from any injuries, pain, suffering, medical expenses, lost wages, and other damages arising from my participation or observation of any of the Activities. This full release also applies to any injuries I sustain while touring “Equipoise” or otherwise physically located in Equipoise. I also fully release Equipoise, LLC, Davis Fox Group, LLC, and all of their employees, members, owners, and operators, in the event I am injured, to (in their own complete discretion), render first aid, seek medical assistance, transport me to a medical facility, call an ambulance, or decide that none of the above is necessary.

Signature :_____ Date:_____