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.

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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.

<u>Individual Rights</u>

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.

Effective Date *This Notice is effective January 1, 2004 and revised June 19, 2018 and applies to All protected health information contained in your medical records maintained by us.*

One on One
PHYSICAL THERAPY

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:
Info@onetherpy.com (attn: Privacy Officer)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care,(The Company) **One on One 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.

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**

CREDIT CARD AUTHORIZATION FORM

I hereby authorize One on One Physical Therapy to charge this card for the Physical Therapy Services provided.The card will be charged only on dates of service or for late cancellations/no shows appointments described and agreed upon in the Financial Agreement.

Credit card information will not be stored on site to protect patient's privacy and financial information.

Name for the Account

Company/Individual Name:____

Address:____

City:_______________________State______Zip_________

Phone#: ___________________________ Fax#: _____________________________

Email address:____

Card Type:(circle one) Visa Mastercard American Express Discover

Card Number: ____

Expiration Date:______________ CVV Code:___________

Signature:____

One-on-One Physical 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 Physical 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 Physical 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 Physical Therapy 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 charge

1 One on One
PHYSICAL THERAPY

Case History

Name:______________________

Age:________

Primary Care
Physician:________________________

How did you hear about us?________________

Primary Complaint:
____

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

- ☐ Chronic Symptoms ☐ Unknown
- ☐ Motor Vehicle Acc ☐ Overuse
- ☐ Sports/Rec Activity ☐ Trauma
- ☐ Work related Injury ☐ Other_____

___Gradual? ___Sudden?

Which of the following describes the recent symptom trends? (Circle One)
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	
Ascending Stairs	☐ YES	☐ NO
Bathing	☐ YES	☐ NO
Carrying up to 25 lbs	☐ YES	☐ NO
Childcare	☐ YES	☐ NO
Defecation	☐ YES	☐ NO
Descending Stairs	☐ YES	☐ NO
Deskwork/Computer	☐ YES	☐ NO
Dressing	☐ YES	☐ NO
Driving	☐ YES	☐ NO
Exercise	☐ YES	☐ NO
Grooming	☐ YES	☐ NO
Housework	☐ YES	☐ NO
Kneeling	☐ YES	☐ NO
Lifting< 25lbs	☐ YES	☐ NO
Lifting>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
Urination	☐ YES	☐ NO
Walking	☐ YES	☐ NO
Work activity	☐ YES	☐ NO
Yardwork	☐ YES	☐ NO

ALL INFORMATION ON THESE FORMS ARE CONFIDENTIAL

One on One PHYSICAL THERAPY

Pain Scale

At best?__________ At Worst?__________

(Use this scale to answer questions below)
0) No Pain
1) Mild Pain: you are aware but it doesn't bother you
2)Mild Pain: you become more aware of it, but only begins to bother you
3) Moderate pain: tolerable without meds
4) More severe pain: requires medication
5) Severe pain: You feel antisocial
6) Severe Pain: Can not participate in recreational activities
7) Very Severe Pain: Can not participate in daily living activities
8) Intensely Severe Pain: Can not leave the house
9) Extremely Severe Pain: Can not get out of bed
10) Most Severe Pain: You contemplate Suicide

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

__ Dull __ Radiating __ Numbness
__ Sharp __ Pins & Needles __ Steady
__ Pulsating __ Throbbing

What is the frequency of your pain?

__ Constant
__ Occasional (less than daily)
__ Intermittent/daily
__ Sporadic (less than weekly)

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

__ Modifying your activities __ Heat
__ Cessation of Activity __ Ice
__ Lying down __ Rest
__ Medication __ Sitting
__ Standing __ Walking

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

__ Modifying activities __ Heat
__ Cessation of activities __ Ice
__ Lying down __ Rest
__ Medication __ Sitting
__ Standing __ Walking

Prior Episodes

Have you had prior episodes of this condition?

__ YES __ NO If yes, answer the following:

Which treatments have you had for **THIS** condition?

__ Acupuncture __ Bed Rest __ other
__ Chiropractic __ Injection
__ Massage Therapy __ Medication
__ Physical Therapy __ Surgery

Have you undergone any of the following diagnostic testing?

__ Nerve Conduction __ Doppler Studies
__ CT Scan __ X-rays __ Bone Scan
__ Urinalysis/ Urodynamics __ MRI __ Other
__ Cardiac Stress Test __ Blood __ Ultrasound

Results from above tests:____________________

Lifestyle

Which best describes your general health?

__ Excellent __ Good __ Fair __ Poor

How would you consider yourself generally?
Sedentary Physically Active

What is your occupation?

____

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One on One
PHYSICAL THERAPY

Fall History

Injury as a result of a fall in the past year?
___YES ___NO If yes, date of fall:__________

2< falls in the past year? ___YES ___NO

If yes, dates of falls:________________________

Medical History

Condition	YES	NO
Allergies	___YES	___NO
Anemia	___YES	___NO
Anxiety	___YES	___NO
Arthritis	___YES	___NO
Asthma	___YES	___NO
Bladder Incontinence	___YES	___NO
Bowel Incontinence	___YES	___NO
Cancer	___YES	___NO
Cardiac Conditions	___YES	___NO
Cardiac Pacemaker	___YES	___NO
Circulation Problems	___YES	___NO
Currently Pregnant	___YES	___NO
Depression	___YES	___NO
Diabetes	___YES	___NO
Difficulty Breathing	___YES	___NO
Dizzy Spells	___YES	___NO
Endometriosis Eating Disorder/ Disordered Eating	___YES	___NO
Fractures	___YES	___NO
Gallbladder Problems	___YES	___NO
Gynecological Condition	___YES	___NO
Hepatitis	___YES	___NO
High Blood Pressure	___YES	___NO
HIV	___YES	___NO
Kidney Problems	___YES	___NO
Metal Implants	___YES	___NO
Multiple Sclerosis	___YES	___NO
Osteoporosis	___YES	___NO
Parkinsons	___YES	___NO
Painful Periods	___YES	___NO
Prostatitis	___YES	___NO
Recent Fever	___YES	___NO
Rheumatoid Arthritis	___YES	___NO
Seizures	___YES	___NO
Silicone Implants	___YES	___NO
Strain W/ Urination	___YES	___NO
Strokes	___YES	___NO
Thyroid Disease	___YES	___NO
Tuberculosis	___YES	___NO
Urgency with Urination	___YES	___NO
Vision Problems	___YES	___NO
Weight Loss	___YES	___NO

For Women Only

Pregnancies: **Yes NO**
Vaginal C-Section
# of Children____________

ALL INFORMATION ON THESE FORMS ARE CONFIDENTIAL

1 One on One
PHYSICAL THERAPY

Other (List Below):

____
____
____

Surgery History

Surgery: Date:

Surgery: Date:

Current Medications

Drug: Dosage: Reason

Drug: Dosage: Reason

Other

In the past month have you experienced?

☐ Night Pain ☐ Night Sweats

☐ Unresolved Fever ☐ Nausea

☐ Loss Of Consciousness ☐ Unexplained Weight loss or gain

During the last month have you been feeling depressed or hopeless? ☐ YES ☐ NO

During the last month have you experienced little interest or no pleasure in doing things?

☐ YES ☐ NO

Is this something for which you would like help with? ☐ YES ☐ NO

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Authorization for release/disclosure of protected health information

Patient's Full Name:______________________ Date Of Birth:________________

Date:______________________ Who referred you to us ___________________________

We would like to coordinate your care with other caregivers and therapists you are currently working with by signing this agreement you agree to allow us to share your progress and treatment with related physicians, therapists, and fitness coaches.

I hereby authorize **One on One Physical Therapy Inc.** to release my protected health information or treatment regimen to the people listed below:(Please provide full names)

Primary MD__________________________ Specialty MD____________________________

Chiropracter__________________________ Massage Therapist_______________________

Gym/Studio___________________________ Club/Organization/Team__________________

Other:

____

____

If you do NOT wish to include some of the information to a certain entity please list the person(s) you do not wish your information to be disclosed to .

____

___________________________________ _________________

Signature of Patient or Legal Representative Date

Informed Consent and Liability Waiver and Release

Physical therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, ethnicity, creed, or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention. Treatment may consist of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential for recovery within their capabilities. All procedures will be thoroughly explained to you before you are asked to perform them. You are expected to fully cooperate with the evaluation and treatment program. Because of the nature of services provided, you may be asked to disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request another therapist.

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing levels of difficulty that could increase your level of pain or discomfort with a current or previous injury. You will be able to stop treatment at any time if you feel any discomfort or pain. Your therapist will take every reasonable precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. You should inform your therapist if you experience an increase in your current level of pain or discomfort or an aggravation of your existing injury. By signing below, you acknowledge that you have consulted with your physician to make sure that it is appropriate for you to participate in physical therapy in light of any medical conditions that you may have.

One on One Physical Therapy, Inc. cannot make any promises or guarantees regarding a cure for, or improvement of, your condition. Your therapist will share with you his or her opinion about potential results of physical therapy treatment for your condition and will discuss treatment options with you before you consent to treatment. If you do not wish to participate in the recommended therapy program, you should discuss your alternatives with your physician. By signing below, you acknowledge that you are participating in these sessions at your own risk and will not hold those named below responsible in the event that you incur an injury or exacerbate any previously existing conditions.

By signing below, and based on the above information, you expressly waive, release, and discharge One on One Physical Therapy, Inc. and its officers, directors, employees, agents, affiliates, successors and assigns (which are collectively referred to as "the Released Parties"), from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by you, or to any property belonging to you, while participating in physical therapy treatment, or while on or upon the premises where the physical therapy is being conducted. Further, you covenant not to sue or assert any such claims against the Released Parties, and forever release and discharge the Released Parties from liability for such claims.

BY SIGNING THIS DOCUMENT, YOU CONFIRM TO ONE ON ONE PHYSICAL THERAPY, INC., FOR THE BENEFIT OF THE RELEASED PARTIES (AS DEFINED ABOVE), THAT YOU HAVE CAREFULLY READ THIS DOCUMENT AND FULLY UNDERSTAND ITS CONTENTS, VOLUNTARILY AGREE TO EACH OF ITS TERMS AND PROVISIONS, AND SIGN OF YOUR OWN FREE WILL.

Signature of client:______________________________

Printed name of client: ___________________________

Date: _____________________________

If Under 18 Years of Age:

Signature of Parent or Legal Guardian: ______________________________

Printed Name of Parent or Legal Guardian:____________________________

Relationship to client:____

One on One
PHYSICAL THERAPY

Permission to Photograph/Video

I grant One on One Physical Therapy, its representatives and employees, the right to take

Photographs/videos of me and my property in connection with the above identified subject. I authorize

One on One Physical Therapy, its assigns and transferees to copyright, use and publish the

same in print and/or electronically.

I agree that One on One Physical Therapy may use such photographs/videos of me with or without

my name and for any lawful purpose, including for example such purposes as publicity,

illustration, advertising, social media and web content.

I have read and understand the above:

Signature: __________________________ Printed Name: ____________________

Signature of parent or guardian (if 18 or under): __________________________________

Date:____

One-on-One Physical Therapy • 3300 NE Expressway Bldg. #8, Suite C • Atlanta, GA 30341
T (770) 500-3848 • F (678) 868-1114 • www.onetherapy.com