Fit Club Physical Therapy & Sports Performance
Info@fitclubny.com
(646) 875-8348

MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name: _____ Date of Birth: _____/_____/_____ Age: _____
Telephone Number:_____ Email:_____
Address:_____
Do you have a prescription? Y N
Referring Physician: _____ Phone #: _____
Address: _____

Condition to be treated: _____
Date Condition Began: _____

Please check all that apply)

_____ Heart Disease	_____ Diabetes	_____ High Blood Pressure	_____ Pacemaker
_____ Cancer	_____ Tuberculosis	_____ Visual Impaired	_____ Epilepsy
_____ HIV/AIDS	_____ Arthritis	_____ Hearing Impaired	_____ Stroke
_____ Fibromyalgia	_____ Asthma	_____ Latex Allergy	_____ Scoliosis
_____ Osteoporosis	_____ Hepatitis	_____ Other (if checked, please explain)	

_____

Therapist's comments:

_____

Have you had surgery for your condition? Y N If yes, date: _____
Is condition related to an auto accident? Y N If yes, date: _____
Is condition related to non-work accident? Y N If yes, date: _____
Is condition related to work accident? Y N If yes, date: _____
Have you had any injections for your condition? Y N If yes, date: _____
Please list any diagnostic tests you have had for this condition:

_____

Please list any medications that you are taking: _____
How did the injury or problem occur? _____

Please rate your pain using a 0 - 10 scale (0=no pain, 10= the worst pain you can imagine)
Worst pain since onset: _____ Pain at best since onset: _____ Today's pain _____
Where is your pain or problem located? _____
Is your pain…. Constant Intermittent Dull Sharp Other _____
What makes your pain/problem better? _____
What makes your pain/problem worse? _____
Is there pain present at night? Y / N What position helps you sleep? _____
Have you had PT for this condition? Y / N If yes, where? _____
Have you had chiropractic services
for this condition? Y / N If yes, where? _____

Therapist's Comments:

_____

Employment History:
Are you currently working Y N If no, how many total days of work have you missed? _____
Are your work duties.... Full Restricted How many hours/week do you work? _____
Who is your employer? _____
What type of work do you do? _____
What activities in your daily life or work duties have been most affected by your problem?

_____
What do you hope to accomplish with therapy?

_____

Are you exercising at home? Y N If yes, what type? _____
Are you using heat or cold? Y N If yes, what type? _____
Are you wearing a sling or brace? Y N If yes, what type? _____
Do you smoke? Y N If yes, how much? _____
What type of non-work activities are you involved in? _____
When are you scheduled to see your doctor again? _____

Therapist's Comments:

_____
Therapist Signature: _____

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Fit Club, Inc.

Patient Signature: _____ Date: _____

Authorizations & Acknowledgements

Treatment Authorization: I authorize Physical Therapy treatment of myself or my minor child by the therapists and staff at Fit Club, Inc.

Informed Consent: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me.

The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Physical therapy involves the use of many different types of physical evaluations and treatment. At Fit Club, Inc., we use a variety of procedures and modalities to help us to try to improve your level of function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms, and testing results. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them. If you do not wish to participate in the therapy and/or exercise program, we will discuss your medical, surgical, or pharmacological alternatives with your physician or primary care provider.

Referral Authorization: Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier required an authorization for service, no service will be rendered until the authorization is obtained. Furthermore, we may be required to contact your doctor for a treatment order referral for services.

Assignment of Benefits: I authorize payment of my Insurance benefits to be made directly to Fit Club, Inc. on behalf for physical therapy services rendered. In the event my insurance carrier

does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Fit Club, Inc. within five (5) days of receipt of such payment.

Financial/Insurance Responsibility for all Fit Club, Inc. Services: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for my services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, Fit Club, Inc. will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Fit Club, Inc. to take action to secure payment of an outstanding balance owed.

No Guarantees: I recognize that the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any therapy rendered at Fit Club, Inc.

Revocation of Authorizations: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

Patient Acknowledgement: I certify that the information I provide to my doctors , therapists, and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

Payment Authorization: (Initials required for all 3 statements)

Assignment of Insurance Benefits : I authorize that the payment of my insurance benefits be made directly to Fit Club Inc. for all services delivered; if I am paid directly I will promptly pay Fit Club Inc. all monies paid to me

_____ Initials

Guarantee of Payment: I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date

_____ Initials

Certification of Information: I certify that the information I have provided Fit Club Inc. for payment including , but not limited to, Related accidents, illnesses or other insurers is accurate and truthful.

_____ Initials

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my therapist the nature and purpose of Physical Therapy treatment in general and my treatment in particular (including my individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the Physical Therapy treatments offered or recommended to me by my Doctor and/or Physical Therapist. I intend this consent to apply to all my present and future Physical Therapy care. I attest, to the best of my knowledge , the above information is accurate and true.

Patient or Legal Representative's Signature	Date
Print Name	

Informed Consent and Waiver & Release of Liability

I have volunteered to participate in a program of health care (possibly including but not limited to physical therapy, Yoga, Personal Training, and/or Massage) and to retain the services of Fit Club Inc. and its employees, independent contractors and/or any future employees or independent contractors to receive said services. I intend to assume all risk of injury from my participation. To that end, I acknowledge and agree to all of the following:

1. The treatment may include but is not limited to one or more of the following: evaluation, manual therapy, joint mobilization and manipulation, soft tissue mobilization, therapeutic exercise, neuromuscular re-education, therapeutic activities, and modalities including but not limited to ultrasound, electrical stimulation, and hot and cold packs. There are inherent risks involved in any evaluation and treatment program. It is not possible to guarantee or give assurance of a successful result. It is important that you understand and agree to the planned treatment. Physical Therapy is generally safe and helpful. However, medical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death). It is important to be aware of the following risks before you receive the treatment you and your health care provider are planning.
2. The possible benefits of this treatment include: decreasing pain, improving cardiovascular fitness, muscle strength, endurance, flexibility, improved body posture, movement and alignment. During treatment there exists a potential for numerous side effects including but not limited to muscle soreness or stiffness; numbness, tingling, or other parasthesias; muscle tears; bony fractures; paralysis; abnormal blood pressure, cerebrovascular accidents, fainting, disorders of heartbeat, and instances of heart attack and death. I assume all of the foregoing risks, and accept personal responsibility for any other damages or other injury I might suffer. I am satisfied with my understanding of the more common risks and complications of the evaluation and treatment.
3. I know I have the right to choose what treatment I do or do not receive in addition to withdrawing from any treatment at any time.
4. I recognize that my participation in the activity covered hereby is contingent upon my signing and returning of this waiver and release. I understand that I may show this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY to, and consult with, my own independent legal counsel before signing.
5. Fit Club Inc. and its employees, independent contractors and/or any future employees or independent contractors have not made any representation as to the nature and quality of the facilities or equipment to be used or as to any other matter related to my participation in the foregoing activity. I understand that the "RELEASEES" enumerated above or otherwise owe no duty or obligation to me.
6. I have read and understood this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY and it accurately sets forth my intentions and I agree to be bound by its provisions.

PRINT NAME: _____

SIGNATURE: _____DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Fit Club Inc. I recognize that outside of purposes for treatment, payment, and certain healthcare operations or as permitted or required by law I must give my written authorization to Fit Club Inc. to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature

PATIENT/CLIENT RIGHTS & RESPONSIBILITIES

It is the practice and commitment of all employees and agents of this facility to respect and ensure the legal, ethical and moral right of the patients and clients it serves. Furthermore, every effort will be made to stay abreast of these rights and provide an environment that promotes human dignity as a founding service.

Each Patient has the Right to:

- Be greeted and treated with care and in a courteous & dignified manner.
- Be assigned to the appropriately educated, trained, and skilled individual without regard to race, creed, gender, national origin, disability, religion, sexual orientation, health status or age
- Expect that all care will be delivered by or under the supervision of a physical therapist or physical therapist assistant and that the identity of the individuals delivering care will be readily available
- Be serviced in a facility that is fully compliant with federal, state, and local regulations
- Be given information regarding his/her care or potential care in a timely manner and in a manner in which he/she can understand the procedure(s), the purpose, the potential outcomes, the alternatives and the risks and benefits associated with recommended care or the lack of it
- Be given the opportunity to participate in his/her care and care decisions including the declining part or all of the plan of care
- Expect that his/her protected health information (PHI) will be handled, secured or disposed of in full compliance with federal privacy & security regulations requiring that access to PHI be given on a 'need to know basis' only and that the use of this information without authorization is prohibited with the exception of treatment delivery, healthcare operations and related billing services. This PHI includes, includes but is not limited to , diagnosis, prognosis, past history, treatment, clinical and billing records and any personally identifying data, such as address, SS#, etc.
- Review and or have access to his/her clinical record, in all formats: paper, electronic, etc. and obtain copies if requested at a reasonable charge
- Be treated in an environment that is safe and accessible to the fullest extent of the law
- Be duly and timely informed of any financial responsibilities that he/she will have as a result of rehabilitative, educational or injury prevention intervention.
- Request and receive an itemized statement for all services delivered, regardless of payor source
- Be informed of any financial relationships that this facility has with any payors, referrers, other healthcare entities/practitioners and/or vendors.

Each Patient/Client has the Responsibility to:

- Give complete, accurate and timely medical, personal demographic and payor information to this facility
- Comply with the rehabilitative plan of care (per informed consent) to the best of his/her ability which includes, but is not limited to, following home programs/instructions, punctually attending scheduled treatment sessions and adhering to known precautions and limitations
- Advise his/her therapist when rehabilitative goals or treatment approaches require modification secondary to external complicating factors including, but not limited to, physical or mental health, family, work or religious conflicts or commitments
- Adhere to obvious department guidelines while at this facility including, but not limited to, courteous interaction with staff, other patients/clients and visitors, conscientious personal hygiene and modesty and respect for treatment and clinical record confidentiality for self and others
- Provide objective complaint notification to the Directors or his/her designee as well as the state Licensing Boards and/or other regulatory agencies, if indicated.

48 HOUR CANCELLATION POLICY

A minimum of **48 hours** of notice must be given prior to your scheduled appointment to cancel your therapy/training appointment or you will be charged a $50 cancellation fee. Fit Club Inc. urges you to keep every appointment, as consistent treatment will expedite your recovery. Arrival more than 30 minutes after the time of your scheduled appointment may be considered a failed appointment. Rescheduled appointments with less than 48 hours notice must be rescheduled for the same week. Thank you in advance for your compliance.

I have read and understand the cancellation policy,

_____ _____/_____/_____

Signature of Client Date