WHITE BAY P.T. INC

Patient Information Sheet

Personal Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ DOB: _____ Social Security #: _____

Email: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Referring Physician Name: _____ Phone: _____

Insurance: (Circle one) MEDICARE COMMERCIAL PRIVATE PAY

Primary Insurance Company: _____

Name of Insured: _____ Relationship: _____ Self _____ Spouse

Date of Birth: _____ Policy Identification #: _____

Secondary Insurance Company: _____

Name of Insured: _____ Relationship: _____ Self _____ Spouse

Date of Birth: _____ Policy Identification #: _____

FINANCIAL RESPONSIBILITY I understand that my insurance contract is between me, my employer and the insurance company and that WHITE BAY PT INC is not a party to that contract. I understand that WHITE BAY PT INC will contact my insurance company (including Medicare) to verify my benefits, but that it is my responsibility to understand what is covered and required under my policy. I acknowledge that providing accurate insurance and other information is critical to determining patient eligibility and benefits available. I understand that WHITE BAY PT INC will bill my insurance carrier (including Medicare) for services rendered upon verification of coverage by my insurance company. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payments, including if I am denied benefits under workers compensation, I understand that I will be responsible for the balance due in full. I understand that I am responsible for paying my co-payments, co-insurance (including co-insurance from Medicare) and deductibles at the time of service which I acknowledge may be an estimate at that time. Further, I understand that federal and state laws and insurance company contracts prevent WHITE BAY PT INC from adjusting, writing off or waiving co-payments, co-insurance (including co-insurance from Medicare) and deductibles. I also understand that I am responsible for any balance due after payment by my insurance company. Pursuant to the assignment of benefits herein; I hereby request that my insurance carrier make payment directly to WHITE BAY PT INC for all services rendered by this facility. If my current policy prohibits direct payment to WHITE BAY PT INC, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to: WHITE BAY P.T. INC 1954 NW 170TH TERRACE PEMBROKE PINES FL 33028. If my insurance carrier makes payments to me I agree to immediately pay over these funds to WHITE BAY PT INC. I also authorize WHITE BAY PT INC to deposit check received on my account when made out to me. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. **ASSIGNMENT OF BENEFITS** I, the undersigned, hereby assign to WHITE BAY P.T. INC (hereinafter "Assignee") any and all rights, claims, benefits, and causes of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred on _____. This is to act as an assignment of my rights and benefits to the extent of Assignee's services provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection, including attorney's fees and costs.

INITIALS _____

Consent to Receive Medical Care: I give authorization to WHITE BAY P.T. INC and/or its staff and agents to evaluate and treat me during my participation in therapy (this includes immediate First Aid and treatment, physical exam, follow-up care, exercise, and rehabilitation). I understand that any WHITE BAY P.T. INC Physical Therapy staff has the authority to prevent me from further participation because of an injury and/or because of any undue liability to WHITE BAY P.T. INC.

INITIALS: _____

Health Insurance Portability and Accountability Act Release (HIPAA): I have read and fully understand the Notice of Privacy Practices. I was given a copy of the Notice of Privacy Practices and hereby give WHITE BAY P.T. INC permission to release my medical information for purposes of billing and medical consultation.

INITIALS: _____

Assumption of Risk: I understand that although WHITE BAY P.T. INC and its staff take precautions to safeguard my health and safety, serious and potentially debilitating injuries can and do occur while participating in physical activity. I know that it is extremely important that I consider and be ever mindful of the risks that are involved in such activities as Physical Therapy. I feel comfortable with and accept these risks and hereby release Physical Therapy and Wellness,LLC and its entire staff from any and all liability.

INITIALS: _____

Attendance Policy: I understand that I am responsible for my appointed times and will give 24 hour notice for cancellation or be subjected to a $20 cancellation fee. There are no guarantees to resheduling since openings due to cancellations are unpredictable.

INITIALS _____

Consent for Treatment in a Group Setting: WHITE BAY P.T. INC in compliance with Federal HIPAA Regulations is committed to protecting our patient's health information and privacy. Our therapists and staff will be making every effort to ensure that your protected health information ("PHI") is kept private. However, due to the nature of the open setting of our therapy area, your treatment may be performed in the presence of other individuals. In some instances it is possible that other patients, family members or friends, and staff will overhear information relating to your treatment, diagnosis, and insurance benefits. Unless you indicate in writing to the contrary, by signing this Consent Form you are agreeing that it is possible for other patients to overhear trivial information regarding your treatment and consenting to the disclosure of this inconsequential information to any other individuals who may be present in the therapy area.

INITIALS _____

Direct Access- no RX required: I agree to be evaluated and treated by a therapist without an Rx from a physician or other healthcare practitioner per Florida Statute- 30 consecutive days (4 weeks) from date of evaluation. A signed POC or RX by a Healthcare Practitioner of choice after 30 days would need to be obtained for continued care.

INITIALS: _____

PRINTED NAME: _____

SIGNATURE _____ DATE: ____/____/___

SIGNATURE OF RESPONSIBLE PARTY OR GUARDIAN _____DATE: __/__/__

WHITE BAY P.T. INC

NOTICE OF PRIVACY PRACTICES 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 medical information is the information gathered by your therapists or other caregivers during the time you are being treated by WHITE BAY PT INC. It is private, and no one without a legitimate need to know may have access to it. WHITE BAY PT INC. is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. In the unlikely event that your medical information becomes unsecured, WHITE BAY PT INC. will provide you with prompt notification. WHITE BAY PT INC. will not use or disclose your health information except as described in this Notice of Privacy Practices ("Notice"). This Notice applies to all of the medical records generated during your participation in WHITE BAY PT INC programs and services. EXAMPLES OF DISCLOSURE FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS The following categories describe the ways that WHITE BAY PT INC may use and disclose your health information: Treatment: WHITE BAY PT INC will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your physician, consulting physician(s), nurses and other healthcare providers who have a legitimate need for such information in the care and continued treatment of the patient. Payment: WHITE BAY PT INC may release medical information about you for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third-party payor or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, a bill sent to a third party payor may include information that identifies you, your diagnosis, the procedures and supplies used. Routine Healthcare Operations: WHITE BAY PT INC may use and disclose your medical information during routine healthcare operations, including quality assurance, utilization review, internal auditing, accreditation, certification, licensing or credentialing activities of each rehabilitation clinic ("Clinic"), medical research and educational purposes. Business Associates: WHITE BAY PT INC may use and disclose certain medical information about you to its business associates. A business associate is an individual or entity under contract with WHITE BAY PT INC to perform or assist WHITE BAY PT INC in a function or activity that necessitates the use or disclosure of medical information. Examples of business associates include but are not limited to, a copy service used by the Clinic to copy medical records, consultants, independent contractors, accountants, lawyers, medical transcriptionists and third party billing companies. WHITE BAY PT INC requires the business associate to protect the confidentiality of your medical information. In addition, WHITE BAY PT INC requires any subcontractor of WHITE BAY PT INC business associate to protect the confidentiality of your medical information. Regulatory Agencies: WHITE BAY PT INC may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, billing practices may be audited by the State Auditor and records are subject to review by the Secretary of Health and Human Services and his/her authorized representatives. Workers' Compensation: WHITE BAY PT INC may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illnesses. Military

WHITE BAY P.T. INC

NOTICE OF PRIVACY PRACTICES

Veterans: WHITE BAY PT INC may disclose your medical information as required by military command authorities if you are a member of the armed forces.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, WHITE BAY PT INC , may release your medical record information to the correctional institution or law enforcement official. Required by Law: WHITE BAY PT INC will disclose medical information about you when required to do so by law. Other Uses: Any other uses and disclosures will be made only with your written authorization.

PATIENT INFORMATION RIGHTS

Although all records concerning your treatment obtained at WHITE BAY PT INC are the property of WHITE BAY PT INC , you have the following rights concerning your medical information: Right to Confidential Communications: You have the right to receive confidential communications of your medical information by alternative means or at alternative locations. For example, you may request that WHITE BAY PT INC contact you only at work or by mail. Right to Inspect and Copy: You have the right to inspect and copy your medical information. Right to Amend: You have the right to amend your medical information. Any request for amendment should be submitted to V in writing, stating a reason in support of the amendment. Right to an Accounting: You have the right to obtain an accounting of the disclosures of your medical information made during the preceding six (6) year period. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your medical information. WHITE BAY PT INC is not required to honor your request except where: (i) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law, and (ii) the medical information pertains solely to a healthcare item or service for which you, or person other than the health plan on your behalf, has paid WHITE BAY PT INC in full. Right to Receive a Paper Copy: You have the right to receive a paper copy of this Notice. Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your medical information, except to the extent that action has already been taken in reliance on your authorization. A request to exercise any of these rights must be submitted, in writing, to WHITE BAY PT INC . Forms to help you make your request are available in the Clinic.

FOR MORE INFORMATION OR TO REPORT A PROBLEM If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with WHITE BAY PT INC , please contact the Front Desk located near the front entrance to the Clinic. All complaints must be submitted in writing. Forms are available in the lobby of the Clinic. There will be no retaliation for filing a complaint. CHANGES TO THIS NOTICE WHITE BAY PT INC will abide by the terms of the Notice currently in effect. WHITE BAY PT INC reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. An updated version of the Notice may be obtained at the Clinic. NOTICE EFFECTIVE DATE: May 2015