BE STRONG
THERAPY SERVICES
Physical and Occupational Cancer Rehabilitation

New Patient Demographic Form

Today's Date: ___ /___ /____

First Name:_____ Middle Initial:_____ Last Name: _____

Date of Birth: ___ /___ /____ Gender: M F

Race: Caucasian African American Hispanic Asian Other:_____

Best Phone Number to leave a message: _____

Email: _____

Appointment Reminder Method (circle): Email Text Phone Call

Street Address: _____City:_____State/Zip: _____

Emergency Contact: _____Phone:_____Relationship: _____

BE STRONG
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Physical and Occupational Cancer Rehabilitation

New Patient Intake Form

Today's Date: ___ /___ /____

First Name:_____ Middle Initial:_____ Last Name: _____

Date of Birth: ___ /___ /____

Marital Status (circle one): Single Married Widowed Divorced

With whom do you live? _____

Occupation:_____
If retired or disabled enter your last occupation

Retired? No Yes Date of retirement:_____
Disability ? No Yes Date of disability:_____
Highest Level of Education:_____

List your Doctors Involved in your care:
Primary care doctor: _____ Medical Oncologist: _____
Radiation Oncologist: _____ Surgeon: _____
Cardiologist: _____ Neurologist: _____
Podiatrist: _____Gynecologist: _____
Other: _____

Do you have any allergies? (circle one) Yes No
If yes, please list: _____
_____
_____
Do you smoke? No Yes How many years did you smoke? _____
If you quit, when did you stop?: _____ How many packs per day ? _____

Have you Ever Been Treated for any of the following:

History of poor Circulation	Yes No	Diabetes	Yes No	Vertigo/Dizziness	Yes No
High Blood Pressure	Yes No	High Cholesterol	Yes No	CHF	Yes No
Breathing problems Asthma or COPD	Yes No	Neuropathy	Yes No	Sleep Apnea	Yes No
Stroke	Yes No	Heart Attack	Yes No	Anemia or low blood count	Yes No
A-fib	Yes No	Thyroid Problems	Yes No	Kidney Problems	Yes No
Arthritis	Yes No	Depression/Anxiety	Yes No	Cancer	Yes No

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PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

_____
_____
_____

PLEASE LIST ANY Surgeries:

_____
_____
_____

Do you have any history of falls? (circle one) Yes No
If yes, please explain: _____
_____
_____

Do you have any difficulty doing day to day tasks? (circle one) Yes No
If yes, please explain: _____
_____
_____

What are your goals for therapy? What do you want to get out of coming here:

_____
_____
_____

Are you currently receiving home health services?:

_____
_____
_____

How did you hear about us?:

_____
_____
_____

BE STRONG
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INFORMED CONSENT FOR BE STRONG THERAPY SERVICES

This document (the Agreement) contains important information about the professional services and business policies of clinical staff members at Be Strong Therapy Services, LLC. Please read it carefully and note any questions you might have so that they can be addressed during you (or your child's) session. You are asked to sign once you fully understand these policies. Once you sign a copy for your file, it will constitute a binding agreement between you and your clinical staff member. You may revoke this Agreement in writing at any time. That revocation will be binding on Be Strong Therapy Services unless we have taken action in reliance on it; if there are obligations imposed on Be Strong Therapy Services by your health insurer in order to process or substantiate claims made under your policy; of if you have not satisfied any financial obligations you have incurred.

Services Provided: Be Strong Therapy Services provides physical, occupational, speech, and massage therapy. Personal training and fitness classes are also provided. The purpose of these therapies is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery.

Safety/Physical Contact: Be Strong Therapy clinicians will assure to the best of their ability that their clients are kept safe in and around the office and while using equipment. Safety measures such as use of gait belts, wheelchairs, blood pressure cuffs, physical contact, etc., may be implemented to always ensure the safety of the client.

Confidentiality: The only way your Be Strong Therapy clinician will share information about you, your child, or your family with others is if you first sign a “Release of Information” form that specifies who is to receive the information and what is to be shared. You have the right to confidentiality regarding your involvement at Be Strong Therapy Services, LLC. Legal exceptions to confidentiality exist to protect you and others, including the following: threat of grave bodily harm to oneself or another person; child abuse or neglect; requested information from your insurance company; and information a collection agency may require if a patient’s account is delinquent. Please see Be Strong Therapy’s Privacy Practices form for more detailed information.

Benefits and Risks: Physical, speech, massage, and occupational therapy services, as well as personal training and fitness can have benefits and risks. Informed consent means being aware of both possibilities. Benefits include gaining increased independence, increased strength, and endurance, increased functional task completion, decreased pain, and overall greater sense of well-being and health. Response to therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Be Strong Therapy Services does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with your treating therapist throughout your treatment. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

Professional Fees, Payment Policies, & Insurance Reimbursement:
Fees: Physical, speech, and occupational therapy services are billed at $210 for your first evaluation appointment, and $185 per session for treatment. If you have Medicare, these rates will vary based on the federal fee schedule. Personal training services are billed at $120 for 1 hour and massage therapy is billed at $95 per 1hr. Afterwards, Be Strong Therapy may offer promotional pricing and package pricing as deemed appropriate. There is no charge for routine phone calls lasting less than 10 minutes. If phone calls take the place of an in-person appointment, if they last for more than 10 minutes, or if significant amounts of time are needed to coordinate a patient's care with other professionals or institutions, these calls will be charged per 15-minute intervals at the hourly rate of the service to which the call relates.

I understand that my sessions will be billed at the appropriate rate listed above.
_____ (Initials)

If a patient/family become involved in legal proceedings that require the participation of the Be Strong Therapy clinician, the patient/family will be expected to pay for their professional time even if they are called to testify by another party. Because of the difficulty of legal involvement, the fees for preparation and attendance at any legal proceeding are higher than the typical fees and will be discussed with the patient/family if this service becomes necessary.

Payment Policies: Fees are collected at each visit for the hours of service performed that day. Fees for activities conducted between visits (e.g., record review, phone calls of more than 10 minutes, telehealth communications, etc.) will be collected at the next visit or by invoice if there are no further visits scheduled. The patient/family will be expected to pay the outstanding balance at that time. Be Strong Therapy clinicians also cannot accept barter for services.
Payment may be made by cash, check, or credit card at the time of service(s). Please make checks out to Be Strong Therapy Services, LLC.

I understand that I must pay at the time of each visit. I understand that all services provided between visits will be billed and paid at the subsequent visit.
_____(Initials)

Payment delinquencies: There will be a returned check fee of $25.00 should there be any problems clearing a check. If for any reason a patient/family does not pay their bill at the time of service, a $50.00 late fee will be assessed for each 30 days that they do not pay. If a patient/family does not pay their bill for more than 60 days and suitable arrangements for payment have not been agreed to, your Be Strong Therapy clinician has the option of using legal means to secure payment, including the use of collections agencies or small claims court. If such legal action is necessary, the costs of such proceedings will be included in the claim. In most cases the only information released about a patient in such a process would be his/her name, the nature of the services provided, and the amount due.

Insurance Reimbursement: If you have a health insurance policy, it may provide coverage for physical and/or occupational therapy assessment and treatment. Be Strong Therapy Services, LLC, is an out-of-network provider with most insurances. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled. However, you, not your insurance company, are responsible for payment of services at the time of service(s). You should carefully read the section in your insurance coverage that describes out-of-network physical and occupational therapy services. If you have questions about the coverage, call your plan administrator. Be Strong Therapy Services does not guarantee insurance reimbursement.

I have read and understand that I am responsible for therapy fees for services upfront and my insurance may or may not reimburse for therapy services.

_____ (Initials)

Cancellation Policy: Since your appointment time is reserved exclusively for you, if you cancel or do not come, your Be Strong Therapy clinician is often unable to use that time for another patient who needs to be seen. Therefore, once an appointment for any service is scheduled, a patient/parent will be expected to pay for it unless they provide 24 hours advance notice of cancellation. Illness and emergencies are exceptions to this.

I understand that I must cancel the appointment 24 hours in advance, or I will be billed a $25 no show fee for the scheduled appointment.
_____(Initials)

Early Termination (Ending) of Treatment: A decision on the part of your Be Strong Therapy clinician for early or premature termination of the professional relationship would be for one of the following reasons: non-cooperation with the services being provided; lack of maintaining frequency of sessions that would support timely completion of the evaluation, treatment or consultation; needed services that your clinician is not able to provide; financial non-cooperation; or any other needs of the Be Strong Therapy clinician.

Contact Policies & Procedures:
To reach your Be Strong Therapy clinician by phone, please call the main office phone number which is: 850-270-7374 or email hello@bestrongtherapy.com. As Be Strong Therapy clinicians are often not immediately available by telephone, they will check messages during the day, Monday through Friday. Be Strong Therapy clinicians typically do not check messages over the weekend. Be Strong Therapy clinicians will make every attempt to return phone calls as quickly as possible. When your clinician is unavailable, their telephone is answered by confidential voicemail. If your clinician will be unavailable for an extended time (e.g., vacation or illness), they will provide clients with the name of a colleague to contact, if necessary and upon request. If a client wishes to communicate with their clinician by e-mail, it is necessary to sign the Electronic Communications Authorization Form.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during your professional relationship with your Be Strong Therapy clinician. I have received and understood the above information.
I have been given a copy of this form for my records, and I consent to the agreed upon services for myself and/or my child. I agree to meet all financial obligations.
Client' Name _____
Client's Date of Birth: _____
Signature of Client: _____
Signature of Clinician as Witness: _____

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Medical Information Release Form

Patient Full Legal Name: _____ DOB: _____

Email: _____

Phone: _____

Release of Information

( ) I authorize the release of information including the diagnosis, medical and treatment plan records, examination rendered to me any/all claims information. This may be released to:

- ( ) Spouse name and phone number:_____
- ( ) Child(ren) name(s) and phone number:_____
- ( ) Other, relationship, and phone number:_____

( ) Information is NOT released to anyone.

( ) This RELEASE of information will remain in effect until terminated by me in writing.

Messages

Please call my :
( ) Home Phone: _____ ( ) Cell Phone: _____ ( ) Email: _____

If unable to reach me:

- ( ) you may leave a detailed message including medical information on my voicemail
- ( ) please leave a message asking me to return the call

Signed by Patient: _____ Date: _____
Witness: _____ Date: _____

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Electronic Communication Consent Form

Electronic Communication Consent Form Emailing and text messaging (and other online "activities") have become a common and convenient way to communicate with virtually any service provider with whom you work. It is important to be aware, however, that there are uncertainties related to the privacy and confidentiality of electronic communications. The "take home message" of this document is that I cannot ensure the confidentiality of any form of communication through electronic media. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will be glad to do so. Please be advised, however, of the following conditions:

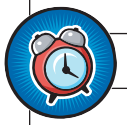
1. Emailing and texting is not appropriate for urgent or emergency situations. I cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
2. Email and texts should be concise. The client should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. All emails and texts may be printed and kept in client's file.
4. Provider will not forward client's identifiable emails and/or texts without the client's written consent, except as authorized by law.
5. Clients should not use email or texts for communication of sensitive personal or medical information, nor should it be used for casual communication.
6. Provider is not liable for any breaches of confidentiality caused by the client or any third party.
7. It is the client's responsibility to confirm and keep all scheduled sessions. I will send a text reminder the day before your scheduled session if requested, see applicable information above regarding confidentiality. I have read the above document and understand the limits of confidentiality regarding electronic communications.

_____ _____ Client's Signature
_____Date

When I get up, I take:

Drug name *(brand name, generic name, dose)*	This looks like	How many?	How I take it	I started taking this on:	I stop taking this on:	Why I take it:	Who told me to take it:

In the afternoon, I take:



In the evening, I take:

Before I go to bed, I take:

Other medicines that I do not use every day:

HIPAA Omnibus
Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at https://www.bestrongtherapy.com/new-patient-intake or calling the Privacy Officer at **850-270-7374**.

Some examples of **Protected Health Information** include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need:
We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to

the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You can ask for a list (accounting) of the times 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 health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at **850-270-7374**, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

Be Strong Therapy Services, LLC

1414 Piedmont Drive East, STE 100
Tallahassee, FL 32308

Phone: 850-270-7374
Fax: 850-273-5629

Health Insurance Portability and Accountability Act of 1996

HIPAA OMNIBUS
NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Revised: March 25, 2013

Kelly Uanino
kelly.uanino@bestrongtherapy.com

By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

BE STRONG
THERAPY SERVICES
Physical and Occupational Cancer Rehabilitation

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Be Strong Therapy Services Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature