MANNING PHYSICAL THERAPY AND SPORTS MEDICINE,INC.

SECTION 1 – PATIENT INFORMATION

Home Phone: ( )_____ Cell Phone: ( )_____
First Name: _____ MI: _____ Last Name: _____
Address: _____City: _____ State: ___ Zip: _____
Sex: M F Date of Birth: _____ Age: _____
Social Security Number: _____
Marital Status: Single Married Divorced Widowed Separated
Referred to our office by: _____
Primary Care Physician (Name/Phone Number): _____
Employer Name: _____ Work Number: _____
Student Status: Full time Part Time
EMERGENCY CONTACT NAME: _____ Phone #: _____
E-mail address: _____

SECTION 2 – INSURANCE HOLDER INFORMATION

Is the Insurance Holder the Patient? _____yes _____no If yes, skip to section 3
Insurance Holder's First Name: _____MI:_____Last Name: _____
Address: _____City:_____State:_____ Zip:_____
Sex: M F Date of Birth: _____ Age: _____ Social Security #: _____
Relationship to patient: Spouse Child Other _____
Employer Name/Address: _____
Occupation: _____Work Phone: _____

SECTION 3 – INSURANCE COMPANY INFORMATION

Name of Insurance Company: _____Phone: _____

Group or Policy #: _____ I.D. #: _____

Secondary Insurance :_____Phone: _____

Group or Policy #: _____ I.D. #: _____

SECTION 4 – RELEASE AND ASSIGNMENT

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize and request payment of medical benefits directly to Provider.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked in writing by me.
4. I agree that a photocopy of this form may be used in lieu of the original.

_____ _____
Signed (Patient or Representative) **Date**

Attention: Payment is to be made at the time of the visit unless prior arrangements have been made with this office.

Cancellation/No Show Policy

Here at Manning Physical Therapy and Sports Medicine, Inc., we realize that once in a while circumstances require you to cancel or miss an appointment and we are happy to reschedule your appointment when this happens.

While canceling appointments can create scheduling problems for us, it also interrupts your rehabilitation program designed to treat your injury/condition. Frequent cancellations and/or no shows make our treatments less effective toward reaching your goals and the goals of your referring physician. Please attend all treatments, if possible, so that together we can reach your full potential and maximum recovery.

It has been shown that patients who attend physical therapy appointments on a regular basis have better outcomes. Actually, two of the most important outcome predictors are:

1. Regular attendance of physical therapy treatments
2. Compliance with home exercise program

As a courtesy to our staff, all our patients, and in order to better serve ALL of our patients, please call us at least 24 hours in advance with your cancellation. In the event that 24 hours notice is not given, a cancellation fee of $ 25.00 will be charged to you. In addition, if you arrive at the wrong time for your appointment, we will make every effort to provide your entire treatment as long as we do not inconvenience those patients already scheduled for that time.

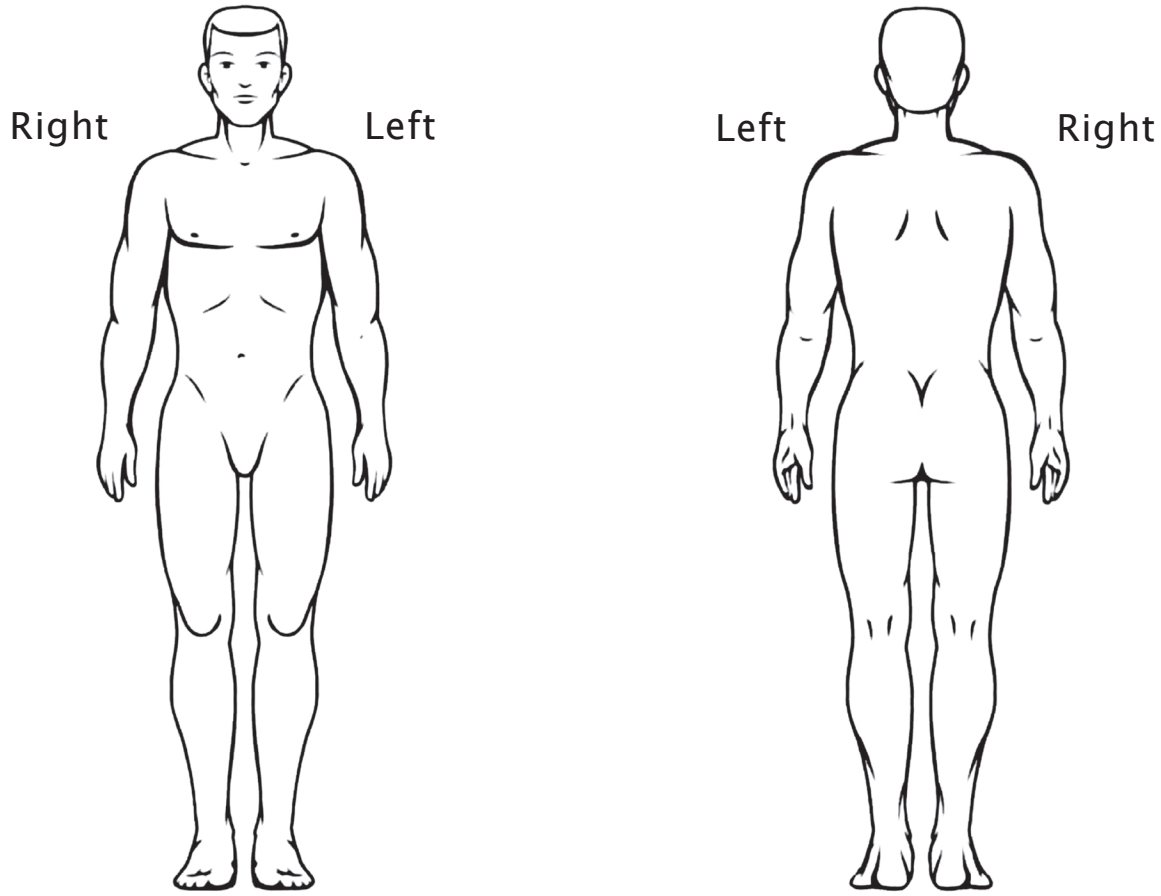
We are pleased that you chose Manning Physical Therapy and Sports Medicine, Inc., for your physical therapy rehabilitation. Please partner with us to help make your recovery here at Manning Physical Therapy and Sports Medicine, Inc., a successful experience.

I have read and understand that if I must cancel an appointment I should do so at least 24 hours in advance, and if 24 hours notice is not given, I will be charged a $ 25.00 cancellation fee.

_____ _____

Signed Date

PLEASE MARK BELOW THE LOCATION OF YOUR SYMPTOMS:



My Chief Complaint is: _____ Date First Symptom of your problem occurred on: _____

Please rate your pain by circling the one number that best describes your pain at its **WORST.**

0 1 2 3 4 5 6 7 8 9 10

No pain Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your **CURRENT** level of pain.

0 1 2 3 4 5 6 7 8 9 10

No pain Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain at its **BEST.**

0 1 2 3 4 5 6 7 8 9 10

No pain Pain as bad as you can imagine

_____

PRINT NAME

PAST MEDICAL HISTORY FORM

	YES	NO
Cancer	_____	_____
• Specify: _____		
Heart Condition	_____	_____
• Specify: _____		
High Blood Pressure	_____	_____
Low Blood Pressure	_____	_____
Pacemaker	_____	_____
Diabetes Type 1	_____	_____
Diabetes Type 2	_____	_____
Neuropathy	_____	_____
Reduced Sensation	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Osteoarthritis	_____	_____
Rheumatoid Arthritis	_____	_____
Gout	_____	_____
Fracture	_____	_____
Hernia	_____	_____
Osteoporosis	_____	_____

	YES	NO
Stroke	_____	_____
Alzheimer's	_____	_____
Parkinson's	_____	_____
Multiple Sclerosis	_____	_____
Epilepsy	_____	_____
Muscular Dystrophy	_____	_____
Traumatic Brain Injury	_____	_____
Polio	_____	_____
Fibromyalgia	_____	_____
Lupus	_____	_____
Anxiety	_____	_____
Depression	_____	_____
Allergies	_____	_____
Anemia	_____	_____
Blood Clots	_____	_____
Hearing Loss	_____	_____
Poor Eyesight	_____	_____
Other: _____		
_____		
_____		

Height: _____ Weight: _____

WORK ACTIVITY: _____ Sitting _____ Standing _____ Light Labor _____ Heavy Labor

HABITS: _____ Smoking (_____ Packs a Day) _____ Alcohol (_____ Drinks a Week) _____ Coffee/Soda (_____ Cups a Week)

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy? _____ YES _____ NO If yes list name:_____

List all medications you are currently taking: _____

_____

_____

List all previous surgeries:_____

_____

Are you pregnant? ___ YES ___ NO

Have you had any injuries related to work? _____ YES _____ NO

If yes list body part and date: _____

Have you had any injuries related to Auto Accidents? _____ YES _____ NO

If yes list body part and date: _____

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

EXHIBIT D - Patient Authorization for Practice to Obtain or Release Protected Health Information

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR §164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes Manning Physical Therapy and Sports Medicine, Inc. (the "Practice") to obtain the personally identifiable health information specifically referenced in this Authorization.

Please read the following information carefully:

I, the undersigned, authorize the use and/or disclosure of personally identifiable health information about me as described below:

1. I authorize the following person(s) or class of persons to use and/or disclose the information:
   _____
2. I authorize the following person(s) or class of persons to receive the information:
   _____
3. The following is a description of the information that I authorize to be used and/or disclosed:
   _____
   _____
4. The information will be used and/or disclosed only for the following purposes:
   _____
   _____
5. I understand and acknowledge that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
6. **(If applicable)** I understand that the Practice will receive compensation for its use and/or disclosure of the information.
7. I understand and acknowledge that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that I may inspect or copy any information used and/or disclosed under this Authorization.
8. I understand and acknowledge that I may revoke this Authorization at any time by sending a written revocation to the Practice at the following address: 3370 Library Road, Route 88, Pittsburgh, PA 15234, Attention: Practice Compliance Director

However, I also understand and acknowledge that if I revoke this Authorization, my revocation will not be effective to the extent that the Practice has already acted in reliance on this Authorization.

9. This Authorization expires _____ _____ (insert applicable date or event).

I understand all of the provisions in this Authorization, and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS AUTHORIZATION AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

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A copy of the completed and signed Authorization form has been provided to the patient or representative:

_____Yes _____No

_____ _____
Signature of Authorized Practice Representative Date

EXHIBIT C - Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Manning Physical Therapy and Sports Medicine, Inc. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:

   3370 Library Road
   Pittsburgh, PA 15234
   Attention: Practice Compliance Director

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.
   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

   _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

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To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____Other (explain) _____

_____ _____
Signature of Authorized Practice Representative Date

EXHIBIT B – Notice of Protected Health Information Practices (Privacy Policy)

PRIVACY NOTICE

NOTICE OF PROTECTED HEALTH INFORMATION 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.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Manning Physical Therapy and Sports Medicine, Inc. ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

    a. **Treatment**. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your physical therapist may disclose your health information when consulting with a physician regarding your medical condition.

    b. **Payment**. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies or portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

    c. **Health Care Operations**. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures With Patient Authorization**. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object**. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

    a. **Uses and Disclosures Required by Law**. We will disclose your health information when required to do so by law.

    b. **Public Health Activities**. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

    c. **Abuse and Neglect**. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

    d. **Regulatory Agencies**. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

    e. **Judicial and Administrative Proceedings**. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

    f. **Law Enforcement Purposes**. We may disclose your health information to law enforcement officials when required to do so by law.

g. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

i. **Threats to Health and Safety**. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. **Military/Veterans**. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.

m. **Appointment Reminders**. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and Disclosures**. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Uses and Disclosures to Business Associates**. With an acknowledgement or a proper authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request. If, however, we agree to the requested restriction, it is binding on us.

2. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. **Right to Verbally Object**. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. **Right to Seek an Amendment of Your Health Information**. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. **Right to an Accounting of Disclosure of Your Health information**. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request; provided, however that we need not provide an accounting for any information disclosed prior to April 14, 2003. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to the April 14, 2003 compliance deadline under the Privacy Regulations. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. **Right to Confidential Communications**. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. **Right to Revoke Your Authorization**. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

8. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at 412-819-0991. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact the Compliance Officer at 412-819-0991. All complaints must be submitted to the Practice in writing at 3370 Library Road, Route 88, Pittsburgh, PA 15234. There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is 10/23/2013.