

## EXERCISE CONSENT FORM

I wish to join/be treated by Magna Physical Therapy & Sports Medicine Center, LLC to improve my fitness level/receive physical therapy. Before entering the program I understand that I will need to complete a medical history form for the purpose of detecting any condition, which may indicate that I should not participate in a fitness program or that my program may need to be altered. I understand that withholding information about my health may result in an incorrect exercise prescription, which may cause harm to me. I understand that if I have certain pre-existing medical problems, or if concerns develop during the course of my health history, the staff will request information from my physician, and will request his/her consent for my participation. I understand the staff will review all data submitted and develop a safe and effective exercise program for me. All information received or generated about me is strictly confidential.

I understand that no assurance can be given to me that participation in a fitness program will increase my functional/athletic capacity, improve my blood sugar and blood pressure, assist in weight loss and tone my muscles; however current research indicates that improvement in these areas can be achieved with active participation in an exercise program. In addition, feelings of increased confidence and a sense of well being usually occur.

The exercises are designed to place a gradually increasing workload as tolerated on my cardiovascular and musculoskeletal system and thereby improve its functioning. The reaction of my body cannot be accurately predicted. I understand the risks associated with exercise include blood pressure abnormalities, lung congestion, irregular heartbeats, muscle pain and soreness, and in very rare instances a "heart attack", "stroke" or "cardiac arrest." I understand that the Magna Physical Therapy & Sports Medicine Center staff will take all measures to avoid such happenings. I understand that providing the staff with current information about changes in my health, which includes any illness or symptoms I experience in the performance center or at home, is essential for the Magna Physical Therapy & Sports Medicine Center staff to determine if any modifications need to be made in my exercise program. I understand that if I do not inform the Magna Physical Therapy & Sports Medicine Center staff that I may be putting myself at risk for injury or serious medical problems.

I understand that I am required to respect the rights of all participants and staff members involved with the Magna Physical Therapy & Sports Medicine Center. I understand that the staff has the right to address concerns about my health with my physician and may ask to temporarily discontinue my exercise program until my physician evaluates my condition and advises me on my return.

I acknowledge that no guarantees can be made to me as a result of my participation in the program. I hereby release Magna Physical Therapy & Sports Medicine Center, LLC, its affiliated entities, employees, trustees and their respective representatives and agents from all claims, liabilities, and causes of action arising or associated with my participation in this program. I have read the foregoing or it has been read to me, and I understand its contents and significance.

Client/Participant/Guardian **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

MPT&SMC Witness **Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

## INFORMATION / CONSENT FOR CARE & TREATMENT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Marital Status: M S

Occupation: \_\_\_\_\_ Primary Insurance: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care MD: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist MD: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Magna Physical Therapy & Sports Medicine Center? \_\_\_\_\_

Would you like information about our Personal Training programs or Pilates Classes? Yes No

Are you interested in Nutritional Counseling? Yes No

**Do you wish to speak to a social worker at this time? Yes No**

- It is our policy that office visits be paid for at the time services are rendered, this includes co-payments and deductibles. Once your insurance carrier processes your claim we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **Magna Physical Therapy**.
- The above may not apply for those patients that are considered Worker's Compensation, Medicare Primary or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
- In an effort to keep costs low, **Magna Physical Therapy** does not accept credit or debit cards. Payments must be made by cash or check.
- We verify your insurance benefits as a courtesy to you. However, **Magna Physical Therapy** does not accept responsibility for any incorrect information given by your insurance carrier regarding your insurance benefits or benefit plans.
- 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.
- I, the undersigned, do hereby agree and give my consent for **Magna Physical Therapy** to furnish medical care and treatment to be considered necessary and proper in diagnosing or treating his/her physical and mental condition.
- I hereby authorize **Magna Physical Therapy** to release all information necessary, including medical records to secure payment.
- **I understand I will be charged a \$25 No-Show fee if I fail to keep an appointment without at least twenty-four hour notification.**

All of the above information is correct to the best of my knowledge:

**Patient/Client/Guardian/SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on September 01, 2006, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. We will attempt to disclose only information that is pertinent to your care.

**Treatment:** We may use or disclose your medical health information to a physician or other healthcare provider providing treatment to you as is necessary to benefit your health.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. This information will be limited to your medical information, unless specifically requested by medical insurance and we obtain your release.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

**Your Authorization:** Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death.



302 W. Main St. Suite 204  
Avon, CT 06001  
860-679-0430 Phone  
860-679-0431 Fax

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters) that disclose medical information and appointment times.

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your healthcare information. You must allow at least 48 hours for our staff to accommodate these requests. If you prefer, we will prepare a summary or an explanation of your health information for a nominal fee. Contact us using the information listed at the end of this Notice.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement ( except in an emergency).

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

## QUESTIONS AND COMPLAINTS

If you have questions or concerns about our privacy practices please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Brian A. Magna

Telephone: 860-679-0430 Fax: 860-679-0431

302 W. Main Street, Suite 204 Avon, CT 06001

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date : \_\_\_\_\_

## Medical History

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Do you experience or has a physician told you that you have:

	<b>Circle One:</b>	<b>Comments:</b>
Allergies	Yes No	
Anemia	Yes No	
Anxiety	Yes No	
Arthritis	Yes No	Location:
Asthma/ Shortness of breath	Yes No	
Cancer	Yes No	
Cardiac Conditions (arrhythmia, heart disease, angina)	Yes No	
Cardiac Pacemaker	Yes No	
Chemical Dependency	Yes No	
Circulation Problems (phlebitis, claudication, etc)	Yes No	
Currently Pregnant	Yes No	
Depression	Yes No	
Diabetes	Yes No	
Dizzy Spells/ Headaches	Yes No	
Emphysema/Bronchitis	Yes No	
Fractures	Yes No	
Gallbladder Problems	Yes No	
Hepatitis	Yes No	
Hernia	Yes No	
High Blood Pressure	Yes No	
High Cholesterol	Yes No	
Incontinence	Yes No	
Kidney Problems	Yes No	
Liver Disease	Yes No	
Metal Implants	Yes No	
Multiple Sclerosis	Yes No	
Osteoporosis	Yes No	
Parkinsons	Yes No	
Rheumatoid Arthritis	Yes No	
Seizures	Yes No	
Smoker (previous or current)	Yes No	
Speech Problems	Yes No	
Strokes	Yes No	
Thyroid Disease	Yes No	



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Hearing Problems	Yes	No
Vision Problems	Yes	No
Speech Problems	Yes	No
Sensory Problems	Yes	No
Back Pain	Yes	No
Neck Pain	Yes	No
Knee Pain	Yes	No
Gout	Yes	No
Swollen Feet/ Ankles	Yes	No
Joint Disease	Yes	No
Other condition*	Yes	No

\*If answered "yes" to "other condition", please explain: \_\_\_\_\_

Have you had an injury as a result of a fall in the past year? Yes No

Have you had two or more falls in the last year? Yes No

Do you currently exercise? Yes No

If so, how many times per week? \_\_\_\_\_

How long per session? \_\_\_\_\_

What types of exercise? \_\_\_\_\_

Have you received any of the following treatments in the past year:

Chiropractic	Yes	No	Speech Therapy	Yes	No
Home Care Physical Therapy	Yes	No	Occupational Therapy	Yes	No

Please list any surgeries you have had:

1. \_\_\_\_\_ Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_  
 2. \_\_\_\_\_ Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_  
 3. \_\_\_\_\_ Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Please list any medications you are currently taking or attach a medication list:

Drug	Dose	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Client/Patient/Guardian Signature:

\_\_\_\_\_ Date: \_\_\_\_\_