The ExerScience Center

24706 State Road 54
Lutz, FL 33559
Phone: (813) 803-7070

Patient Information Sheet

Name: ____ **Date of Birth:** ______________________

Home Phone:_____________________________ **Cell Phone:**__________________________________

Address: ____

City: ______________________________________ **State:** _____________ **Zip:** __________________

Email Address: _____________________________________**SSN:**______________________________

Emergency Contact: ______________________________________ **Phone:** ______________________

Insurance Carrier: _____________________________ **Phone Number:**__________________________

Member ID:__________________________________ **Group Number:**_________________________

Policy Holder:_________________________**Date of Birth(policy holder):**_______________________

Physician(first & last): __________________________________ **Phone:**_______________________

Diagnosis:____

Patient Information release Authorization and Assignment of Insurance Benefits

Please be aware that all medical information is confidential under certain state and federal laws. Such information is may not be released without your consent. Many insurance carriers require medical information to be submitted with claims to evaluate medical necessity. Please provide your written consent to release related information when required or requested to your insurance company(s) and/or your healthcare team.

I,____________________________________, do hereby authorize The ExerScience Center, to acquire from and/or release to my healthcare team and /or my insurance company(s), any information required for the purposes of healthcare management and/or for processing all medical claims on my behalf. I understand that upon acceptance of treatment from The ExerScience Center, I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I authorize The ExerScience Center to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to The ExerScience Center. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to The ExerScience Center. I have read and completed this form and certify that all the above information is correct to the best of my knowledge.

____ ______________________

Signature of Patient **Date**

____ ______________________

Parent (if patient is a minor) **Date**

The ExerScience Center

PATIENT NAME:_________________________________

MEDICAL HISTORY / BODY / PAIN CHART AND ADL SCREEN

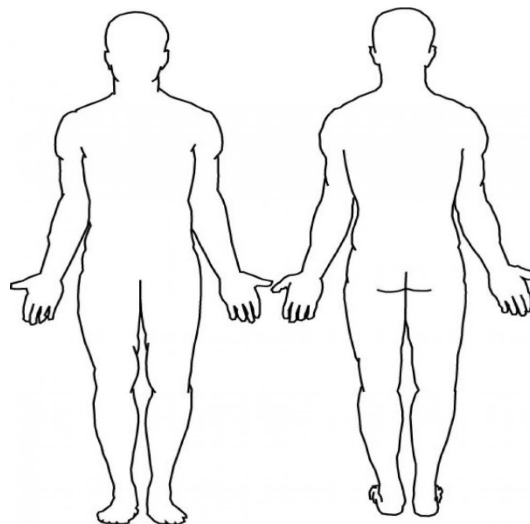
Diagnosis as stated to you by your physician: ______________________________ Date of onset? ____________
How did this injury/exacerbation occur? ____
Have you been hospitalized for the present condition? ☐ Yes ☐ No If Yes, Date: ____________________
Have you had surgery for the present condition? ☐ Yes ☐ No If Yes, Date: ____________________
Have you received previous treatment for this condition? ☐ Yes ☐ No If Yes, Date: ____________________
If Yes, please summarize: ____
Are you currently receiving or have you received in the last 30 days any other home health, medical or chiropractic services rendered to you by any other agency, organization or individual? If yes, please summarize:
____
Are you on medications? Please list (you may use back of page) ______________________________
Have you ever had any of the following? ☐ EMG ☐ CAT SCAN ☐ MYELOGRAM ☐ MRI ☐ XRAY
Have you ever, or are you presently being treated for any of the following conditions?

Condition	Yes	No
Diabetes	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Pregnancy	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Back Injury	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Fracture	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Metalology (implants)	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis A, B, C	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
list:		
Other:		

Please circle all that may apply. My pain is worse:
in the morning / during the day / at night / with activity / during rest

On a scale of 0 – 10,
(0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best ______ and at its worst ______

____
Using the key provided below, please draw the symbol representing your pain over the area of the body as it relates to your present condition.



Key

↓ or ↑ Radiating Pain
XXX Spasm
ZZZ Tenderness
/// Numbness
*** Tingling
000 Aches / Pain

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? Check all that apply.

☐ Getting in/out of bed
☐ Getting in/out of a car
☐ Getting in/out of a chair
☐ Walking up/down the stairs
☐ Getting in/out of the shower
☐ Other: ________________
☐ Personal hygiene activities
☐ Bathing/Shower
☐ Brushing teeth
☐ Dressing
☐ Work Activities
☐ Eating
☐ Sleeping
☐ Sitting
☐ Standing
☐ Walking
☐ Shaving
☐ Lifting
☐ Cooking
☐ Laundry
☐ Driving
☐ Cleaning
☐ Writing
☐ Shopping
☐ Vacuuming

Patient's Signature: ______________________________________ Date: ______/______/________

I have reviewed the above information

Therapist Signature: ______________________________________ Date: ______/______/________

The ExerScience Center

Physical Activity Readiness Questionnaire (PAR-Q)

Please list any medical issues that you have been treated for or are currently undergoing.

____

Are you currently experiencing any pain during daily activities? If yes, please explain.

____

Have you previously or currently had any heart conditions? Stroke, heart attack or heart surgery?

____

Have you been told to only participate in physical activity recommended by a doctor?

____

In the past month, have you had chest pain when you were not doing physical activity?

____

Do you lose balance because of dizziness or do you ever lose consciousness?

____

Have you ever been told by a doctor that you have bone, joint, or muscle problem that could be made worse by physical activity?

____

The ExerScience Center

Physical Activity Readiness Questionnaire (PAR-Q) Cont.

Do you have a diagnosed illness that could be made worse by physical activity?

____

Is your doctor currently prescribing medication for your blood pressure or heart condition?

____

Do you know of any other reason why you should not do physical activity?

____

Please list any medications or supplements you are currently taking.

____

Do you have any allergies? Please list.

____

If you are a female, could you be pregnant?

☐ Yes ☐ No

Please check one, if applicable

Male 45 and older ☐

Female 55 and older ☐

N/A ☐

The ExerScience Center

NEUBIE INTAKE FORM

CLIENT INFORMATION

Name:____Date of Birth:______/______/

Address:____

City:__________________State:__________________Zip:__________________

Phone:______________________Email:__________________________________

Emergency Contact Name and Phone Number: ____________________________________

Reason for visit/Goals:____

How did you hear about us? ____

CONSENT TO RECEIVE REHAB/FITNESS SERVICES: I hereby consent to receive rehabilitation, recovery and/or fitness training services from the service providers at The ExerScience Center. I understand that some protocols may involve the placement of electrode pads on my hips, pelvis, and/or buttocks, as well as other areas of my body, and I will allow The ExerScience Center Practitioners to place the electrode pads on the locations mandated by the NeuFit protocols. If at any point I feel uncomfortable with something I am being asked to do, I will bring it up to The ExerScience Center Practitioner and reserve the right to stop any activity with which I am uncomfortable.

Signed:____________________________________Date:______/_____/______

RELEASE OF LIABILITY: In conjunction with my services at The ExerScience Center and as part of the consideration for my treatment and/or training, I, my heirs, executors, spouse, successors, assigns, offspring, agents, and representatives expressly release, hold harmless, and indemnify The ExerScience Center, NeuFit, its owners, agents, employees, representatives, assignees, licensees, and invitees, from all liability for any services rendered.

Signed:____________________________________Date:______/_____/______

MEDICAL ACCEPTABILITY: I am aware that this work can be physically demanding, and assert that I have been cleared for rigorous exercise by my medical professional. I also acknowledge that use of electrical stimulation is contraindicated by the following conditions, and I assert that I do not have (please place a checkmark in the box to indicate that you do not have the following conditions):

☐ Cancer ☐ Blood Clots ☐ Any implanted electrical device

☐ Epilepsy ☐ I also assert that I am not Pregnant

Signed:____________________________________Date:______/_____/______

FEES: I acknowledge that I am responsible for any and all fees incurred at the time of visit for these services, and I am fully aware of the amount of those fees. Appointments may be canceled by calling (813) 803-7070 at least 24 hours in advance. No-shows and late cancellations will be charged the full cost of the scheduled appointment. Do not email schedule changes or cancellations.

Signed:____________________________________Date:______/_____/______

IMAGE RELEASE: I understand that, from time to time, pictures or videos may be taken of the work that is going on at The ExerScience Center and shared for marketing or educational purposes. I hereby grant The ExerScience Center permission to use my likeness in video or photograph for its printed and digital publications, including social media platforms. I hereby release and hold harmless The ExerScience Center from all claims, demands, and causes of action, which I, or anyone acting on my behalf, may have. In addition, I waive the right to inspect or approve the finished product, and waive the right to any compensation arising out of the use of my likeness in any videos or photographs.

Signed:____________________________________Date:______/_____/______

The ExerScience Center

MASTER DRY NEEDLING

LIABILITY WAIVER

The following is a list of conditions that are the most common absolute and relative contraindications to Dry Needling therapy:

- Spontaneous bleeding or bruising
- Irregular heart beat
- Tendency to bleed (taking anticoagulant therapy)
- Compromised immune system
- Previous adverse reaction to acupuncture or dry needling therapy
- Seizure induced by previous medical procedure
- Unstable diabetes
- Unstable angina
- Congenital or acquired heart valve disease
- Recent cardiac surgery or congestive cardiac failure
- Recent radiotherapy
- Varicose veins
- Malignancy
- Hematoma
- Pregnancy
- Eczema or psoriasis
- Peripheral neuropathy
- Recurrent infections
- Epilepsy--stable or unstable or schizophrenia
- Chronic edema or lymphedema
- Depression
- Chronic fatigue
- Acute cardiac arrhythmias
- Open skin wounds or injuries
- Allergy to Nickel or Chromium
- Human Immunodeficiency Virus (HIV)
- Hepatitis B or C

We strongly advise that you consult your medical doctor if you have any of these conditions to confirm that it is safe for you to attend the practical course. If you are in any doubt please do not hesitate to contact us.

Please notify us if you have had cosmetic or surgical implants inserted into your body including, but not exclusive to breast, buttock or pectoral implants.

The possible risks and adverse reactions to dry needling therapy include but are not limited to temporary pain, bleeding, bruising, infection, dizziness, nerve injury, pneumothorax, pregnancy termination, blood pressure changes, rash, fainting, muscle soreness & fatigue.

A published paper referenced below detailed adverse events as follows: **Serious Adverse Events** (AE's): pneumothorax, cardiac tamponade & damage to organs ***(0.04%).*** **Mild or moderate** AEs: bruising (7.55%), bleeding (4.65%), pain during treatment (3.01%) and pain after treatment (2.19%). **Uncommon** AEs: aggravation of symptoms (0.88%), drowsiness (0.26%), headache (0.14%), and nausea (0.13%). **Rare** AEs: fatigue (0.04%), altered emotions (0.04%), shaking, itching, claustrophobia, and numbness (all 0.01%).

Brady, S et al. Journal of Manual and Manipulative Therapy 2014, Vol. 22, No. 3, 134-140

My signature below affirms the following statements:

There is some risk involved in any procedure that involves inserting needles of any kind into the body. It is possible to puncture organs (for example, lungs) or blood vessels. The most serious risk, although it is extremely rare, is pneumothorax secondary to lung puncture. I understand hematomas can develop secondary to needle insertion. The possibility of accidentally inserting needle into a nerve also exists. I am also aware that vasovagal reactions sometimes occur, resulting in fainting. Infections, though rare, have been reported. I understand that relatively benign and rarely more serious adverse events may occur. I also understand the risk of serious harm is highly unlikely.

LIABILITY WAIVER SIGNATURE

____
Printed Name

____
Signature

____
Date

*****Female attendees must sign below to affirm they are not pregnant.**

The ExerScience Center

Financial Policy

Patient Name:______________________________ **Date:** ____________________

The ExerScience Center and affiliated companies, collectively known as "The ExerScience Center", are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "NEW CLIENT FORM" BEFORE STARTING SERVICE.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER, AND ZELLE.**
- **THE EXERSCIENCE CENTER PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minors Accompanied By An Adult

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at the time of service.

Unaccompanied Minors

The parents or guardians are responsible for full payment at the time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card, or Discover. We do not accept American Express payments for visits by unaccompanied minors.

Insurance

The ExerScience Center provides insurance company billing as a courtesy to our patients. The patient portion of particular service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitations for the amount of services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by The ExerScience Center staff regarding his/her remaining benefit in any such benefit period
The claims we submit to insurance companies indicate that you have assigned those benefits to The ExerScience Center. However, if you are paid by the insurance company instead of The ExerScience Center, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

Medicare/ Medicaid/ Champus/ Worker's Compensation

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the The ExerScience Center office on the date of service.

Delinquent Payments

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

Missed Appointments

No-shows and late cancellations without 24 hour notice will be charged the full cost of the scheduled appointment. Do not email schedule changes or cancellations. This will be your responsibility; insurance cannot be billed for this amount. This fee must be paid prior to being seen for your next appointment.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: ______________________________ **Date:** ____________________

Opt-In for Email and Text Communications

You may opt-in to receiving emails and texts as described below. In either circumstance, The ExerScience Center will never ask for credit card numbers via email or text message. If you think you may have received a suspicious email or text from The ExerScience Center, please contact our office immediately at 813.803.7070.

Email Appointment Confirmations
By opting in to email appointment confirmations, you will receive reminders of upcoming appointments, and reminders to schedule appointments.

Text Appointment Confirmations
By opting in to text appointment confirmations, you are authorizing The ExerScience Center to send text message appointment reminders to you on your provided cell phone number. You understand that you may reply with various commands to receive account information such as balances, future appointments, office location and other alerts as described in our Text Message System command list located on the text appointment confirmations page.

You also agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply.

Your enrollment indicates that you represent and warrant that you are the person legally responsible for all use of the accounts, are at least 18 years of age, and agree to all terms and conditions of use for the text messaging services.

The ExerScience Center offers a text messaging system to current patients to receive appointment confirmations, account balance information, and other services and content deemed appropriate. By opting-in to our text message system (via mobile opt-in or automated opt-in), you are providing consent to use personal information to provide the services available by The ExerScience Center, including customized content. Message and data rates may apply; please contact your wireless provider for specific information regarding your text messaging usage and charges.

The text messaging system is provided by The ExerScience Center to our patients on an as-is basis. Data obtained from you in connection with the text message system may include, but not be limited to, your name, address, cell phone number, office and location, future appointment dates and times, and account information. The ExerScience Center is not liable for any delays that may be experienced during the transmission of any messages, as delivery is based on the speed and effectiveness of your wireless provider.

Opt-Out Text Policy
You may opt-out of our text message system by replying with “STOP” or “UNSUBSCRIBE”. You will no longer receive appointment confirmations or other account information via text message if you opt-out of this service.

**The ExerScience Center Text Message System. Message and data rates may apply. By participating, you consent to receive text messages sent by an automatic telephone dialing system. Messages per month vary based on appointments scheduled. Consent to these terms is not a condition of purchase.*

For Help or Support: If you need assistance with your text message appointment confirmations or account alerts, please read the Frequently Asked Questions. If your question is not answered, you may contact us here, or simply reply with the word “**HELP**” to the message you received for assistance.

The ExerScience Center may terminate this agreement and any related services, with or without cause, at any time. All services are provided on an “as is” and “as available” basis without warranties of any kind, either express or implied, including, but not limited to, warranties of merchantability, fitness for a particular purpose or non-infringement. The ExerScience Center expressly disclaims any representation or warranty that the services will be error-free, timely, secure or uninterrupted. No oral advice or written information given by The ExerScience Center, its employees, licensors or agents will create a warranty, nor may you rely on any such information or advice. Under no circumstances will The ExerScience Center or its affiliates be liable for any direct, indirect, incidental, special or consequential damages that result from the use of or inability to use the services, including but not limited to reliance on any information obtained from the services, or that result from mistakes, omissions, interruptions, deletion of files, text, or e-mail; loss of or damage to data, errors, defects, viruses, delays in operation or transmission, or any failure of performance, whether or not limited to acts of god, communication failure, theft, destruction or unauthorized access to records, programs or services. The ExerScience Center reserves the right to modify the terms and conditions of use at any time and without advance notice, and any changes shall be effective upon making the modified provisions available on The ExerScience Center's website, and continued use of the services after any such changes shall constitute your consent to such changes. The ExerScience Center does not and will not assume any obligation to notify you of any changes to the terms and conditions of use. By signing up for this service, you agree that your sole and exclusive remedy to any issues arising from or relating to the services is to discontinue using the services. The terms of this section shall survive termination or revocation of the Patient Communication Consent Form and/or use of the services.

Supported Carriers: AT&T, Sprint, Nextel, Boost, Verizon Wireless, U.S. Cellular®, T-Mobile®, Cellular One Dobson, Cincinnati Bell, Alltel, Virgin Mobile USA, Cellular South, Unicel, Centennial and Ntelos

The ExerScience Center also provides automated opt-in to text message reminders when a valid cell phone number is provided during the patient registration and/or check-in process.

I consent to receiving electronic communications, including email and text messages regarding treatment, payment and health care operations in accordance with this document.

Signature: ______________________________ **Date:** ____________________

The ExerScience Center

MEDICAL and LIABILITY RELEASE

Name of Patient: ___________________________________DOB: _____________

Please tell us of any condition that attending physicians should be aware of:

RELEASE FOR MEDICAL TREATMENT

It is necessary for you to authorize providers (including physicians, ambulances, etc.) to administer treatment in the case of emergency (accident, sudden illness, etc). Therefore, this release is **not complete nor will not be accepted by The ExerScience Center until this form is signed by the participant of legal age or the minor's parent or legal guardian.** This form has to be signed before the start of any training program.

RELEASE AND WAIVER OF LIABILITY

The undersigned hereby acknowledges that participation in any of The ExerScience Center's Physical Therapy/Personal Training and related activities involves an inherent risk of physical injury. Therefore, the Participant of legal age, parent or guardian hereby assume all such risk and do hereby release and forever discharge The ExerScience Center, its owners, officers, employees, and agents from any and all liability, regardless of the nature, arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, damages to property, and the consequences thereof, resulting from the Participant's active participation or involvement in any of The ExerScience Center, activity, or any failure of equipment or defect in the premises.

I have had a physical examination and been given permission by my physician to participate in The ExerScience Center's Physical Therapy/Personal Training, or I have decided to participate without the approval of my physician.

I/We hereby state that -- I am/we are – the parent(s)/legal guardians(s) of the applicant who is under legal age:

Participant Signature: ____

Parent Signature: ____

The ExerScience Center

Health & Fitness Liability Waiver / Informed Consent

"I, ________________________________, have enrolled in the personalized health and fitness program offered through The Exerscience Center. I recognize that the program may involve strenuous physical activity including, but not limited to, muscle strength and endurance training, cardiovascular conditioning and training, and other various fitness activities. I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in this exercise program. I acknowledge that my enrollment and subsequent participation is purely voluntary and in no way mandated by The Exerscience Center." "In consideration of my participation in this program, I, _____________________, hereby release The Exerscience Center and its agents from any claims, demands, and causes of action as a result of my voluntary participation and enrollment." " I fully understand that I may injure myself as a result of my enrollment and subsequent participation in this program and I, ______________________________, hereby release The ExerScience Center and its agents from any liability now or in the future for conditions that I may obtain. These conditions may include, but are not limited to, heart attacks, muscle strains, muscle pulls, muscle tears, broken bones, shin splints, heat prostration, injuries to knees, injuries to the back, injuries to the foot, or any other illness or soreness that I may incur, including death."

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

______________________________________ ____/_____/______

Client Testimonial Provider Printed Name Date

_______________________________________ ____/_____/______

Signature or Signature of Parent/Guardian (if under age of18) Date

Notice Of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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 Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct certain mistakes on your medical record
- Request confidential communication
- Ask us to limit the information we share under certain circumstances
- Get a list of certain disclosures of your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- 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.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/ hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/ noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Organizations
This Notice of Privacy applies to all affiliated entities doing business as The ExerScience Center.

Contact

The ExerScience Center
24706 State Road 54
Lutz, Fl 33559
Phone: 813-803-7070
Email: info@theexersciencecenter.com

Effective Date of this Notice: July 1, 2020

The ExerScience Center

HIPAA Privacy Practices Acknowledgment

Section A: Patient Information

Patient Name: ____

Patient Number: ____

Section B: Acknowledgment Of Receipt Of Hipaa Notice Of Privacy Practices

Notice of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Acknowledgment. We encourage you to read our Notice carefully and completely before signing this Acknowledgment.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain an additional copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

The ExerScience Center
Telephone: 813.803.7070
Email: info@theexersciencecenter.com

Section C: Signature

I, ______________________________ have had full opportunity to read and consider the contents of this Acknowledgment and the Notice of Privacy Practices. I understand that, by signing this Acknowledgment, I am giving my authorization to your use and disclosure of my protected health information in accordance with the Notice.

Signature: ______________________________ Date: ______________________

If this Acknowledgment is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ______________________ Relationship to Patient: ______________________

Section D: For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other *(please specify)*: ______________________________

Signature: ______________________________ Date: ______________________

You are entitled to a copy of this acknowledgment after you sign it.

The ExerScience Center

HIPAA Authorization

HIPAA Authorization for Uses and Disclosures of Protected Health Information

Authorization of Uses and Disclosures.
I hereby authorize and direct The ExerScience Center as well as their associated dentists, providers, employees, office staff, and agents including affiliated health care practitioners (collectively "The ExerScience Center") to use and disclose my "protected health information" ("Information"), as described below.

Description of Information.
I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information, including information about my health condition and related medical conditions, medical records, and financial information (including information about my insurance) as well as other personal information collected by The ExerScience Center about me or otherwise provided by me to The ExerScience Center.

Purposes.
I authorize and direct The ExerScience Center to use my Information, and to disclose my Information for the following purposes:

a. **For marketing communications.** For example – The ExerScience Center may contact me about new products, services, or events that it thinks may be of interest to me. The ExerScience Center may also contact me for the purposes of fundraising, publicity and advertising for broadcast in print or other media including on the internet. Note that The ExerScience Center may receive remuneration, either directly or indirectly, in exchange for making these marketing communications.

b. **For purposes related to treatment, payment (e.g., to a parent, other family member or personal representative who may assist in coordination of my care) and/or The ExerScience Center health care operations, with the following individuals:**

Name:________________________________

Relationship:________________________________

Telephone Number: ________________________________

Treatment not Conditioned; Signing is Voluntary.
I understand that The ExerScience Center will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization and will still be able to receive treatment. In addition, if I refuse to sign this Authorization The ExerScience Center is still permitted to make uses and disclosures of my Information for treatment (e.g., to other health care providers), payment (e.g., to my insurance company), and health care operations (e.g., for internal audits), as permitted by law.

Expiration.
Unless revoked, this Authorization will expire ten (10) years from the date signed below.

Revocation.
I understand that I have the right to revoke this Authorization by providing written notice of my desire to revoke to **The ExerScience Center**, however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

Potential for Redisclosure.
I understand that Information disclosed pursuant to this Authorization may be redisclosed by The ExerScience Center and may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal privacy law.

Copy.
I understand that I will be provided with a copy of this signed Authorization.

I hereby certify that I am over the age of 18 and I have read the foregoing and fully understand the contents.

Name *(please print)*: ____

Patient Signature: ____________________________ Date:________________

Date of Birth:____________________________ Age: ________________

Parent/Guardian/Personal Representative Signature (required if subject is under 18 years of age)

Description of Relationship to Patient: ________________________________

Health Information Portability and Privacy Act

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. If you have any questions about this notice, please contact The ExerScience Center and/or personnel that provided your services. For your convenience, a listing of contacts is provided on the last page of this notice.

This Notice of Privacy Practice describes how The ExerScience Center may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. The ExerScience Center shall be referred to collectively as "The ExerScience Center" or "we" in this notice, and these referenced include all affiliates of The ExerScience Center which are identified on the last page of this Notice.

It also describes your rights to access and controls your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health records information that we maintain at that time.

Upon your request, we will provide you with any revised Notice of Privacy Practices. This notice became effective on April 14, 2003.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The ExerScience Center understands that medical information about you and your health is personal and confidential. We are committed to protecting medical information about you. We create a record of the care and services you receive at The ExerScience Center. This is needed to provide you with quality care and to comply with certain legal requirements, as well as billing purposes. This notice applies to all records of your protected health information generated by The ExerScience Center.

The ExerScience Center

The ExerScience Center
24706 State Road 54
Lutz, FL 33559
Phone: (813) 803-7070
www.TheExerScienceCenter.com

I have read and understand the Notice of Privacy practices of The ExerScience Center.

______________________________ ______________

Signature of Patient **Date**

______________________________ ______________

Please Print **Date**

I grant permission for The ExerScience Center to speak with the following individuals concerning myself and my treatment plan:

____

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____

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The ExerScience Center

No Show/Cancellation Policy

Pay As You Go -

The ExerScience Center operates on a scheduled hourly appointment basis for Physical Therapy and private training sessions. Therefore, when canceling or rescheduling an appointment, the client is required to provide MORE than 48 hour notice.

A "No Show" is a patient who fails to appear for a scheduled appointment without providing a 48 hour cancellation notice. Further, a rescheduled appointment that is less than the 48 hour cancellation notice is still considered a cancellation and is treated as such. The client will be charged in full for that missed session. This fee will be expected to be paid at your next scheduled visit.

This fee is not covered by your insurance and it will be your responsibility to pay no matter what type of coverage that you have. If the fee is not paid, you will be billed, and this balance is subject to collections.

Exceptions will only be considered in the case of a medical emergency accompanied by a doctor's note. There is a no refund policy, a credit will be issued for a future date. A doctor's note stating you are cleared to continue is required.

Memberships -

When canceling or rescheduling an appointment, the client is required to provide 5 business days' notice or you will lose the session.

If the client is a no show, tries to reschedule, or cancel less than 5 business days to the scheduled time, a loss of session will incur and will not be rescheduled, refunded, or credited.

Exceptions will be considered in the case of a medical emergency accompanied by a doctor's note. There is a no-refund policy on all membership purchases – a client may only receive a credit if accompanied by a doctor's note. A doctor's note stating you are cleared to continue is also required.

Please note that consistent client short notice cancellations and rescheduling does the client and Physical Therapist or Personal Trainer a disservice and will end the partnership with the client.

I have read and understand the Cancellation Policy for The ExerScience Center.

______________________________ ______________

Signature of Patient Date

The ExerScience Center

Policies / Rules and Training Etiquette

1. Clients are required to RSVP to hold their spot. Payments must be made in full before starting any classes.

2. Personal Training sessions are one hour long. If sessions are ended early based on the client's request, the session is considered completed and the remaining time will not be made up during a later date.

3. Be punctual. Clients are expected to begin working out at the start time of their scheduled class. A late start time does not entitle a client to a session longer than the scheduled appointment. Please call your trainer if you are going to be more than 5 minutes late. Trainers will only wait 15 minutes for late arrivals. Any tardiness of more than 15 minutes will result in the loss of that session and the client will not be credited for it.

4. Please devote your full attention to your session. Cell phones and other devices are not permitted. You may take videos and pictures with verbal consent from your trainer.

5. Proper exercise attire is required. The client should wear clothes that are loose and comfortable. But if the client is running or biking, avoid wide-leg or loose pants that could get tangled up in the pedals or your feet. For activities such as yoga or Pilates, stretchy, fitted fabrics that wick away sweat are a good choice. If you are unsure, please don't hesitate to contact The ExerScience Center.

6. If a medical clearance is needed, the initial consultation will be scheduled after your doctor gives written release.

I have read and completely understand these terms.

____________________________________ ____/_____/______

Client Signature Date

The ExerScience Center

Testimonial and Photo Release Form

I understand my testimony may be used in connection with publicizing and promoting The ExerScience Center. I authorize The ExerScience Center to use my name, photograph, brief biographical information, and testimonial.

I grant The ExerScience Center, its representatives and employees the right to use my name, photograph, brief biographical information, and testimonial in various marketing initiatives. I understand that this information may be used in various mediums for such purposes as publicity, illustration, advertising and Web content. I authorize The ExerScience Center to copyright, use and publish these materials in both print and electronic formats for purposes of publicizing The ExerScience Center.

In addition, I waive any right to inspect or approve the finished product wherein my likeness or my testimony appears. I agree that I will make no monetary or other claims against The ExerScience Center for the use of my name, photograph, brief biographical information, and testimonial.

I hereby RELEASE, WAIVE and FOREVER DISCHARGE any and all claims arising out of, or in connection with, such use The ExerScience Center, including without limitation any and all claims for libel or invasion of privacy.

I hereby warrant and represent that I am at least 18 years of age and have the right to contract in my own name. I have read the above Release and am fully familiar with the contents thereof. This Release contains the entire agreement between the parties hereto as to the subject matter contained herein.

I have read, understand and agree to the above.

☐ Yes, I agree with the terms. ☐ No, I do not agree.

____ ____/_____/______

Client Testimonial Provider Printed Name Date

____ ____/_____/______

Signature or Signature of Parent/Guardian (if under age of18) Date