Thank you for choosing Hayes Physical Therapy for your rehabilitation. We look forward to getting you back to being the best version of yourself! Below is our address and some directions on how to get to our practice.

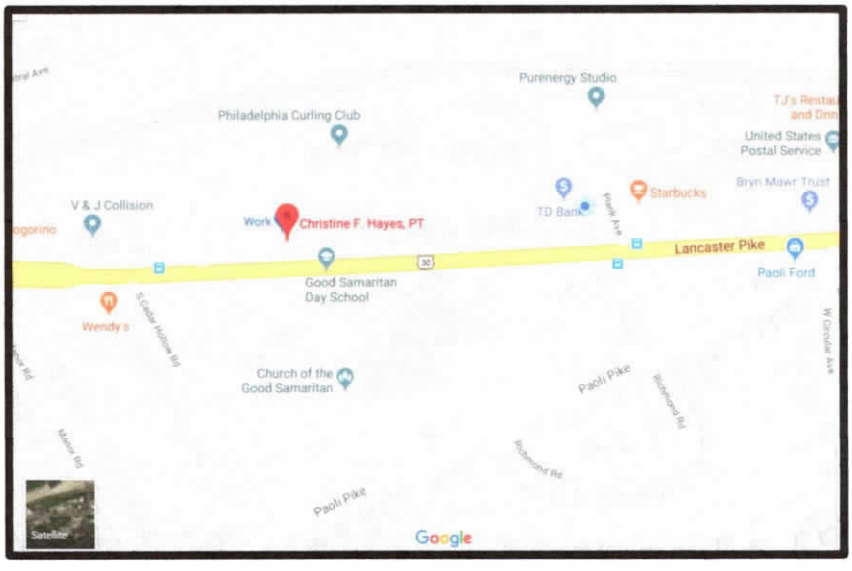
195 W Lancaster Ave. Paoli, PA 19301

The easiest way to get to our parking lot is to turn on **Plank Ave**, which is directly off Lancaster Ave (Rt. 30). Once you turn onto Plank Ave (in between TD Bank and Starbucks) you will take the first left turn after you pass the bank (on your left). You will follow that side street almost to the end where you will see building 195 on your left (tan/beige color). There is also a maroon colored sign that says "Physical Therapy" with number 195 on it. Once at the building please head to the **3rd floor** for your therapy!

If you have any questions please give us a call at 610-695-9913 and we will help anyway we can. Thanks!

See you soon!

Hayes Physical Therapy



Patient Name _____ Date _____

Birthdate _____ Sex M F Marital Status M S W D

Address _____

Cell Phone _____ Home Phone _____

Email Address _____ Preferred Method of Contact _____

Emergency Contact Name _____ Phone _____

Relationship to Patient _____

Are you the primary holder of your insurance? Y N

If you answered "no," please provide the primary holder's legal name, date of birth and relationship to you: Name_____ Birthdate _____

Relationship to Patient _____

If you are coming to us after a motor vehicle accident or with a worker's compensation plan:

Claim Number _____ Date of Injury _____

Contact Person _____ Phone Number _____

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I will inform the front desk staff of any changes to my address, insurance or other provided on this sheet as soon as possible.

Patient/Guarantor Signature _____ Date _____

(Parent if patient is a minor)

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Phone (610) 695-9913 Fax (610) 695-9746

Patient Name _____

How did you hear about us? Please check all that apply:

- ☐ Family or friend : _____
- ☐ Website
- ☐ Facebook
- ☐ YouTube
- ☐ Physician Referral: _____
- ☐ Brochures
- ☐ Newsletter
- ☐ Referral from Integrated Healing Center: _____
- ☐ Workshop
- ☐ Other: _____

195 W. Lancaster Avenue, Suite 3 Paoli, PA 19301
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Appointment Reminder Consent

Complete this form and sign below to give your permission for Hayes Physical Therapy to provide automatic appointment reminder services by email or by cell phone text message.

Step One: Select One Option Below

- ☐ Hayes Physical Therapy may send email messages to confirm my upcoming appointments. The best email to reach me is _____
- ☐ Hayes Physical Therapy may send cell phone text messages to confirm my upcoming appointments. My cell phone number is _____. I recognize that normal text messaging rates/fees may apply.

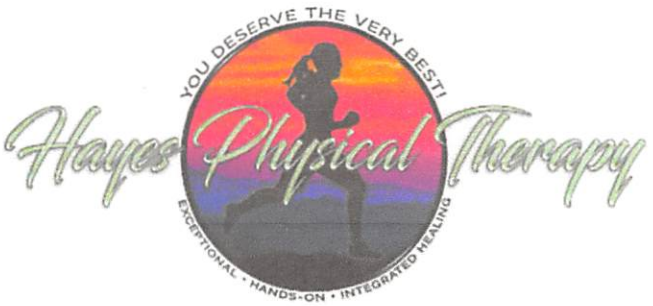
Step Two: If you would like to receive text message reminders, please indicate your cell phone carrier. We cannot set your account up to send text messages without knowing your carrier. Please indicate your carrier below to receive text message reminders of your appointments:

☐ AllTel	☐ AT&T	☐ Boost Mobile	☐ Cingular
☐ Cricket Wireless	☐ Metrocall	☐ Metro PCS	☐ Nextel
☐ Qwest	☐ Spring PCS	☐ T Mobile	☐ US Cellular
☐ Verizon	☐ Virgin Mobile		

Please note: If you are receiving text message or email reminders for your appointments and need to reschedule, cancel your appointment, or contact the office for any reason, please do so by calling us at (610) 695-9913. We are unable to receive replies to our automated service via cell phone and email.

Patient Signature _____ Date _____

195 W. Lancaster Avenue, Suite 3 Paoli, PA 19301
Phone (610) 695-9913 Fax (610) 695-9746



To Our Patients Regarding Cancellations, No-Shows, and Rescheduling

Your referring doctor and/or your physical therapy team have prescribed a set frequency of treatment. We take this subject seriously in our practice as it corresponds directly to your healing time and continuity of care. Arriving as scheduled for these visits is an important responsibility in achieving your set goals.

We require 24-hour notice in the event of a cancellation. It is your responsibility when you call in to have an alternate time in mind to ensure you participate in the prescribed number of sessions weekly.

Our top priority is working towards your complete healing. This requires a dual effort between you and your therapy team. While we understand that true emergencies may arise, work and personal conflicts cannot be considered a reason for a missed appointment without proper notice or failure to reschedule the missed visit.

Your participation in attending the number of weekly visits agreed upon by you and your therapist in your plan of care will optimize your healing in a timely manner. Additionally, maintaining the prescribed number of visits per week also is important to prove "medical necessity" to your insurance carrier. Denial of coverage may happen when an insurance carrier sees inconsistent visits within a given plan of care as it is perceived as a low priority for patient recovery and makes achieving goals difficult.

For our physical therapy patients, there is a $75 charge per cancellation without 24 notice. This charge will not be covered by insurance and will have to be paid by you personally. Whether you cancel with or without notice, we kindly ask you to reschedule any missed appointments within the same week to maintain your plan of care and to optimize the continuity of your healing.

For our private pay/personal training clients, fee for cancellation is equivalent to the monetary rate for your visit that day with a cap of $75 ie: if you were scheduled for a 30-minute visit, you will be responsible for a $60 payment (rate for 30-minute treatment) for the late cancellation.

Please understand that your symptoms may increase and decrease as your treatment progresses. Either condition can seem to be a reason not to come in: A) you're feeling more pain and feeling like therapy isn't working, or B) you're feeling much better and would like to take the day off. Neither of these are a reason to cancel an appointment: A) if your pain has increased, come in to get the pain addressed, and B) if you're out of pain, now is the time to progress towards a higher set of goals and prepare you for discharge.

Patient or Guardian Signature _____ Date _____

Physical Therapist Signature _____ Date _____

195 W. Lancaster Avenue, Suite 3 Paoli, PA 19301
Phone (610) 695-9913 Fax (610) 695-9746

Patient Waiver

The office of Hayes Physical Therapy appreciates the confidence you have placed in us to provide you with rehabilitative care. You have chosen to participate in a service that may require a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your insurance coverage and bill your insurance carrier on your behalf. However, you are still ultimately responsible for your bill.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approval period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to the office of Hayes Physical Therapy for providing rehabilitative services to me. I certify that the information is, to the best of my knowledge true and accurate. I authorize my insurer to pay any benefits directly to the office of Hayes Physical Therapy. I agree to pay Hayes Physical Therapy the full and entire amount of all bills incurred by me, or, if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

(unless patient is a minor)

Consent for treatment and authorization to release information

I hereby authorize the office of Hayes Physical Therapy to release to appropriate agencies, any information in the course of my examination and treatment. I further authorize the office of Hayes Physical Therapy through its appropriate personnel, to perform or have performed upon me, appropriate assessment and treatment procedures relating to the diagnosis on file.

Patient Signature _____ Date _____

To our Medicare patients

Have you had any physical therapy this calendar year? If yes, how many visits _____? Please be advised that the office of Hayes Physical Therapy is required by Medicare to report on measures related to your health. The information which you provide is in accordance with HIPAA regulations and will remain confidential. We appreciate your cooperation in fulfilling this Medicare mandate.

I understand and authorize the information I submit to be utilized for aforementioned purposes.

Patient Signature _____ Date _____

195 W. Lancaster Avenue, Suite 3 Paoli, PA 19301
Phone (610) 695-9913 Fax (610) 695-9746

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 carefully.

1) Uses and disclosures: We will use your protected health information (PHI) for the purposes of treatment, payment, and health care operations.

   Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, and other physical therapists.

   Payment includes the disclosure of health information to your insurance company, including Medicare, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was medically necessary.

   Health Care Operations includes the utilization of records to monitor the quality of care being given at our facility.

   Other Special Uses: Our practice may use your PHI to send you an appointment reminder or to inform you of our other health-related products and services.

   Uses and Disclosures Required by Law

   The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may disclose your PHI when we are required to do so by law such as by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug interactions.

   We may use and disclose health information about you to avert a serious threat to your health or safety or the health and safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

   Your authorization is required before your PHI may be used or disclosed by us for other purposes.

195 W. Lancaster Avenue, Suite 3 Paoli, PA 19301
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2) Your privacy rights:

Restrictions: You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications: You have a right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI: You have a right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and/or mailing.

Ammendments: You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become a part of your record. We may not amend parts of your medical record that we did not create.

Accounting Disclosures: After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous 6 years. These disclosures will not include those made for treatment, payment, or health care operations for which we have obtained authorization.

Complaints: If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect your Policy: We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact: If you would like information about our privacy practices or to file a complaint you may contact:

Christine F Hayes
Practice Owner and Privacy Officer
195 W Lancaster Ave, Suite 3
Paoli, PA 19301
(610) 695-9913

I would like a copy of this notice _____
(please sign if you would like a copy)

I do not want a copy of this notice _____
(please sign if you do not want a copy)

Medical Screening and Systems Review

Name _____ Date _____ Age_____ Height _____ Weight_____

Occupation _____ Leisure Activities _____

Date of injury _____ Describe the reason for your visit _____

_____

When was the onset of injury _____ Onset: Gradual Sudden (please circle one)

How did the injury/problem occur? _____

Was the injury contact or non-contact? _____ Was there any noise associated with onset? _____

Where was the pain initially felt? _____

Where is the pain now? _____

Type of pain (circle all that apply) Dull Sore Constant Intermittent Sharp Throbbing Bruised Burning

Have you had any previous or similar pain or injury? _____

Was there any immediate swelling? _____ How long have your symptoms been present? _____

Are you *currently* seeing any of the following (circle all that apply) Medical Doctor Osteopath Dentist

Psychiatrist/Psychologist Physical Therapist Chiropractor Other _____

If you have been seen by any of the above in the last three months, please describe reasons (illness, medical condition, exam, etc.) _____

Please list any surgeries or other conditions for which you have been hospitalized including approximate date: _____

_____

Please describe any injuries for which you have been treated (fractures, sprains, strains, dislocations, hernia) including approximate date: _____

_____

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Phone (610) 695-9913 Fax (610) 695-9746

Please list any prescription medication that you are currently taking including oral medications, skin patches and injections.

Medication Dose Route (pill, inject) Reason Taken

_____

_____

_____

_____

_____

Please list any vitamins or supplements that you are currently taking.

Supplement Dose Route Reason Taken

_____

_____

_____

_____

Please list any over the counter medications you have taken in the past week: _____

_____

How many caffeinated beverages (coffee, soda, other) do you drink each day? _____

If you currently smoke, how frequently? How many packs per day? _____

How many days per week do you drink alcoholic beverages? _____

Check all that you or a family member have been diagnosed with

☐cardiac conditions/relationship_____ ☐high blood pressure/relationship_____

☐asthma/relationship _____ ☐chemical dependency/relationship _____

☐emphysema/relationship _____ ☐ thyroid problems/relationship _____

☐diabetes/relationship _____ ☐multiple sclerosis/relationship _____

☐ arthritic conditions/relationship _____ ☐ depression/relationship _____

☐hepatitis/relationship _____ ☐ tuberculosis/relationship _____

☐stroke/relationship _____ ☐ kidney disease/relationship _____

☐anemia/relationship _____ ☐seizure disorder/relationship _____

☐other/relationship _____

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Circle all that you have experienced in the past or are currently experiencing:

Cardiopulmonary System: elevated cholesterol sweating with pain palpitations swelling in extremities
smoking history trouble breathing wheezing prolonged cough

GI System: difficulty swallowing heartburn jaundice food allergy constipation diarrhea
rectal bleeding liver condition gallbladder condition

GU System: painful urination incontinence frequency of urination urgency of urination discharge
painful menstruation menopause painful intercourse infertility STD pregnancy

Neurological System: ataxia memory lapse confusion head trauma neurological disorder
tremors slurred speech hearing disturbance visual disturbance

Endocrine System: excessive sweating fatigue global weakness large output of urine

Other Systems: ears, nose, throat skin lymphatic psychiatric musculoskeletal cancer

Please describe if you circled any of the "other" systems above _____

_____

If there is anything else you feel we should know, please use the space below.

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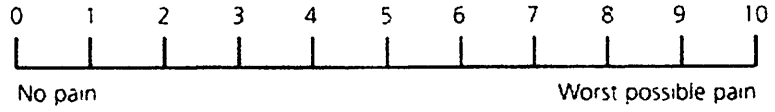
Phone (610) 695-9913 Fax (610) 695-9746

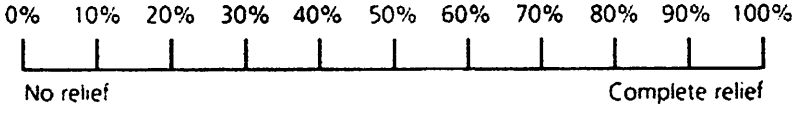
Visual Analog Scale

Please circle the number that best describes your pain



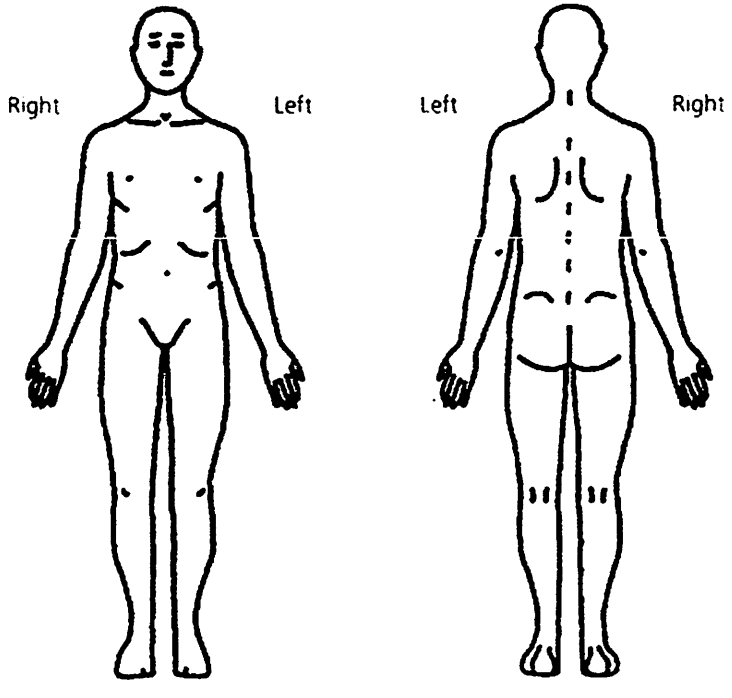
Pain Relief Scale

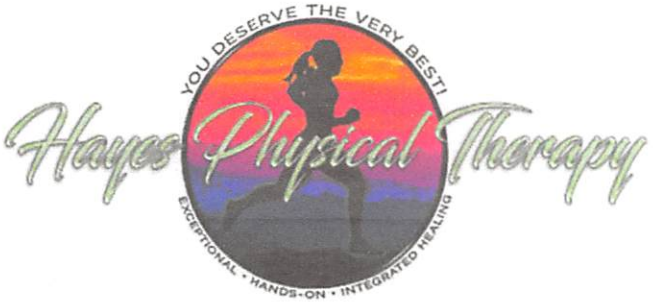
Please circle the percentage that best describes your relief of pain.



Spatial Distribution of Pain

Please mark an X where you hurt most.





Credit Card Authorization Form

I authorize Hayes Physical Therapy to bill the following credit card for services, missed appointments, deductibles, co-insurance or co-pays that have not been paid by my insurance carrier. I understand Hayes Physical Therapy will bill my insurance company and that my credit card may be charged after insurance payment is received. I understand that if my credit card is declined, a $50 fee will be posted to my account. If I fail to respond to monthly statements, collection action may be taken.

Patient Name _____ Date _____

This authorization is to remain in effect until it is cancelled in writing.

The payments I am authorizing are:

☐ Deductible amounts

☐ Weekly Co-payments and/or co-insurance

☐ Any denial of payment from insurance

For your convenience we accept cash, personal checks, Visa, Mastercard, and HSA or FLEX accounts

Name as it appears on card _____ Card Type _____

Card Number _____ Expiration Date _____

CVV Code _____ Authorized Cardholder's Signature _____

Billing address on file with credit card:

Street Address _____

City, State, Zipcode _____

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Phone (610) 695-9913 Fax (610) 695-9746