RADICAL RECOVERY & PERFORMANCE

Welcome! We are pleased that you have chosen Radical Recovery & Performance for your therapy needs. Our goal is to provide you with the highest quality care in a clean and professional environment. Please carefully read the following instructions to prepare you for your first visit.

What to expect the day of your appointment: Before we begin your therapy program, an evaluation will be performed to assess your individual needs. It is important that you come to your evaluation at least 15 minutes early to complete the necessary paperwork.

PLEASE BE PREPARED TO BRING THE FOLLOWING ITEMS TO YOUR APPOINTMENT

1. Therapy prescription from physician
2. Personal identification
3. Insurance card
4. List of medications you are currently taking
5. Comfortable clothing

Appointments: Regular attendance and active participation in your therapy program is necessary for you to get the maximum benefit from our services. It is also important for you to have open communication with your therapist about the therapy being provided and any pain you might be experiencing so that therapy can be adjusted to meet your needs. Our patients are seen by appointment only. It is critical that you are on time for your appointments. Being late may make it necessary to shorten your therapy session so it does not disrupt other patient's scheduled appointments.

Cancellations/Reschedules: Because we provide services by appointment, it is critical that you allow 24-hour notice if you must cancel an appointment. This is a courtesy to the clinical staff as well as to the other patients. Habitual cancellations may lead to discontinuation of services and/or notification to your physician and insurance carrier. If you are more than 15 minutes late and have not contacted Radical Recovery & Performance, we retain the right to consider your appointment a "No Show." As such, we reserve the right to charge Medicare patients a $40 fee and cash-patients the full amount for the session.

We truly do not want to have to charge you for session you did not attend. These policies are in place because we've found that they encourage patient cooperation and engagement in attaining their rehabilitation goals (rather than profiting from lack of compliance). Thank you for your understanding and participation.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

Patient or Guardian Signature

Date

Printed Name

RADICAL RECOVERY & PERFORMANCE

PATIENT INTAKE

Full Name (as it appears on your insurance card)

Preferred Name/Nickname

Street Address City State Zip

Phone Number

Date of Birth

Age Gender

Email Address

INSURANCE INFORMATION

Primary Insurance

Primary Insurance ID Number

Secondary Insurance

Secondary Insurance ID Number

REFERRING PHYSICIAN

Name of Referring Physician

Referring Phone Number

Date of Next Visit to Referring Physician

Primary Care Physician

Primary Care Phone Number

HOW DID YOU HEAR ABOUT RADICAL RECOVERY & PERFORMANCE?

Please specify, so we may say "Thank You"

☐ Physician ☐ Former Patient ☐ Sports Team/Coach ☐ Dance School/Instructor ☐ Internet ☐ Other

Patient or Guardian Signature

Date

RADICAL RECOVERY & PERFORMANCE

INJURY INFORMATION/SYMPTOMS

Date of onset/injury: _____ Are symptoms new? ☐ YES ☐ NO

How did the injury occur? _____

Surgical procedure and date? _____

Describe your physical limitations as a result of your injury/surgery: _____

Describe any activities or movements that aggravate your symptoms: _____

Describe any treatments or movements that decreases your symptoms: _____

Please list any previous injury, conditions, or surgeries: _____

Have you had any of the following diagnostic tests related to your injury? (Mark all applicable)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Doppler ☐ Ultrasound ☐ Other

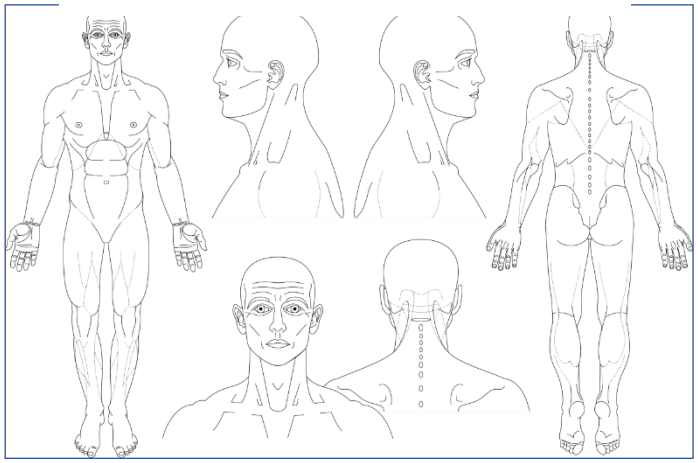
Which of the following describes your pain?
(Mark all applicable)

☐ Sharp ☐ Achy ☐ Burning ☐ Tingling ☐ Numbness ☐ Other:

Please rate your pain: (0=None, 5=Moderate, 10=Severe)

At Present	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10

Please mark all the areas of your symptom(s)



Are you currently taking ANY medications? ☐ YES ☐ NO

Please list ALL medication/dosage or provide written list: _____

Fall History: Is your injury the result of a fall? ☐ YES ☐ NO Have you fallen twice or more in the past year? ☐ YES ☐ NO

Date(s) of fall: _____

HEALTH HABITS AND LIFESTYLE

Is your diet well-balanced? ☐ YES ☐ NO Do you drink water regularly? ☐ YES ☐ NO Glasses/Day? _____

Do you smoke? ☐ YES ☐ NO Daily amount: _____ For how long? _____

Do you drink alcohol? ☐ YES ☐ NO Number/Day? _____ Days/Week? _____

Do you exercise regularly? ☐ YES ☐ NO How often? _____ Type/Program? _____

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MEDICAL HISTORY

Have you been diagnosed with any of the following conditions:

Allergies	Y	N	Depression	Y	N	Kidney Problems	Y	N
Anemia	Y	N	Diabetes	Y	N	Metal Implants	Y	N
Anxiety	Y	N	Dizziness/Ringing in ears/Vertigo	Y	N	Multiple Sclerosis	Y	N
Arthritis	Y	N	Emphysema/Chronic Bronchitis	Y	N	Neurological Disorder	Y	N
Asthma	Y	N	Fibromyalgia/Chronic Fatigue	Y	N	Numbness/Tingling	Y	N
Bladder/Bowel Problems	Y	N	Fractures	Y	N	Osteoporosis/Osteopenia	Y	N
Cancer	Y	N	Gastrointestinal Problems	Y	N	Pain Syndromes	Y	N
Cardiac Disease/Conditions	Y	N	Gallbladder Problems	Y	N	Parkinson's Disease	Y	N
Cardiac Pacemaker	Y	N	Headache/Migraines	Y	N	Seizures	Y	N
Defibrillator	Y	N	Hepatitis	Y	N	Speech Problems	Y	N
Circulation Problems	Y	N	Hernia	Y	N	Strokes	Y	N
Cognitive Disorder(s)	Y	N	High Blood Pressure	Y	N	Thyroid Problems	Y	N
Currently Pregnant	Y	N	Incontinence	Y	N	Vision Problems	Y	N

Have you suffered from any illness not listed above? ☐ YES ☐ NO If yes, please explain: _____

TREATMENT HISTORY

Have you been treated for this condition before? ☐ YES ☐ NO By whom? _____

Was it helpful? ☐ YES ☐ NO Please explain: _____

What are your goals for physical therapy? _____

What do you hope to get from your treatment? _____

What are your current physical or fitness goals? _____

PATIENT STATEMENT OF UNDERSTANDING

I understand, and acknowledge, the following statements:

- Therapy involves patient to provider person to person contact in a professional and medically necessary manner.
- Therapy involves some risks and hazards, most commonly including: Soreness, redness of skin, bruising, swelling, and pain.
- I may seek treatment from any therapy provider/facility that I choose.

I authorize and request Radical Recovery & Performance:

- Perform diagnostic assessments, examinations, procedures, and treatments to assess and treat my condition or injury.
- Release my medical records to any other provider or medical facilities directly involved in my care and for the purpose of administering claims and to obtain medication history for the purpose of treatment.
- Assign payment of my medical benefits to Healing Hands Therapy, LLC.
- Release information regarding my condition and my ability to return to normal activity and/or work to my insurance company/employer/attorney, or their representative.

_____ _____

Patient or Guardian Signature Date

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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for use or disclosure of Protected Health Information

Authorization – I authorize Radical Recovery & Performance to use and discuss the protected health information to referring doctor or physician if needed.

Effective Period – This authorization for release of information covers the period of care from start of physical therapy to your last day of physical therapy.

Extent of Authorization – I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) to Radical Recovery & Performance as it relates to my treatment.

The medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance upon my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient or Guardian Signature _____ Date _____

Printed Name _____

RADICAL RECOVERY & PERFORMANCE

Due to the outbreak of the Coronavirus (COVID-19), Radical Recovery & Performance has taken steps to protect you, our community, and our staff. To this extent, Radical Recovery & Performance will be following the Center of Disease Control (CDC) with regard to social distancing practices, sanitation and disinfection procedures.

SYMPTOMS OF COVID-19 INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING

Fever / Fatigue / Dry Cough / Difficulty Breathing/Nausea

I AGREE TO THE FOLLOWING STATEMENTS:

- ☐ I, nor any member of the household, have not experienced any of the symptoms listed above within the last 14 days.
- ☐ I, nor any member of the household, have traveled internationally in the last 30 days.
- ☐ I, nor any member of the household, do not believe that we have been exposed to someone with suspected and/or confirmed case of the Coronavirus (COVID-19).
- ☐ I, nor members of my household, have not been diagnosed with the Coronavirus (COVID-19) within the last 30 days.
- ☐ Radical Recovery & Performance cannot be held liable from any exposure to the Coronavirus (COVID-19) caused by misinformation on this form or the health history provided by each client.

Radical Recovery & Performance cannot prevent you [or your child(ren)] from becoming exposed to, contracting, or spreading COVID-19 while utilizing the services, and premises. It is not possible to prevent against the presence of the disease. Therefore, if you choose to utilize Radical Recovery & Performance services and/or enter onto the premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself and/or my child(ren) in order to utilize Radical Recovery & Performance services and enter the premises. These services are of such value to me [and/or to my child(ren)] that I accept the risk of exposure to, contracting, and/or spreading COVID-19 in order to utilize the services and premises in person.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against Radical Recovery & Performance and its owners, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to services and the premises. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen, or unforeseen.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL OF THE PROVISION OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE.

Patient or Guardian Signature _____ Date _____

Printed Name _____