Please tell us how you found us:  
(Please check all that apply)

☐ My doctor referred me to your clinic
☐ I found out about your clinic from a friend
☐ I was a previous patient
☐ Family member
☐ I heard about your services from one of your physical therapists
☐ I learned of your clinic from my Insurance Company
☐ I learned of your clinic and services from the internet
☐ Other

Consent to Treat

I do hereby consent to such treatment by the authorized licensed personnel of Collins Physical Therapy Institute as may be dictated by prudent medical practice by my illness, injury or condition.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for assistance. Kindly sign and date this form to indicate that you understand and agree to the terms of this payment/consent to treat.

Please be advised that we are not a credit guarantor. Therefore, failure to maintain these arrangements may result in the placement of your account with an outside collection agency or attorney for collections. You will remain financially responsible for services rendered, regardless of the payment option selected above. In the event your account becomes delinquent and is therefore default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the recovery of this debt.

_________________________  _________________________
Sign Name  Date
Payment Policy

Welcome to Collins Physical Therapy Institute! We are happy to further extend your services by filing your primary and/or secondary insurance for you. Please be sure to read all of the following information carefully:

- According to ________ (insurance carrier) you have satisfied $______ of your $______ (yearly) deductible. The balance of $______ is payable at the time of service (as based upon your insurance's fee schedule).
- A co-payment of $______ and/or ______% is due at each visit.
- Worker's Compensation: We will bill your worker's compensation carrier for all charges.
- Self-Pay: Balance is due in full at the time services are rendered.
- Motor Vehicle you are responsible for ______%
- Will bill Medicare and 2ndary insurance first.

Cancellation Policy

It is our policy to charge a $25 fee for Cancellation or No Show to your appointment. If for any reason you cannot keep your appointment, please call 24 hours prior to your appointment to cancel. This is not covered by your insurance and you will be responsible.

Please Note: It is our policy that the patient will be discharged from our services after three cancellations or no-shows for his/her appointments.

_________________________  __________________________
Sign Name                                      Date

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Collins Physical Therapy Institute's Notice of Patient Information Practices. I understand that Collins Physical Therapy Institute may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Collins Physical Therapy Institute's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_________________________
Patient Name

_________________________  __________________________
Signature (Guardian if patient is a minor)                                      Date
Name: ___________________________  SSN: ___________________  Date: ____________

Leisure activities, including exercise routines:

Occupation, including activities that comprise your workday:

Age: ___________________  Height: ___________________  Weight: ___________________

Are you on a work restriction from your doctor? Yes  No  Are you latex sensitive? Yes  No  Do you smoke? Yes  No  Do you have a pacemaker? Yes  No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes  No

ALLERGIES: List any medication(s) you are allergic to:

<table>
<thead>
<tr>
<th>Have you RECENTLY noted any of the following (check all that apply)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>fatigue</td>
</tr>
<tr>
<td>fever/chills/sweats</td>
</tr>
<tr>
<td>nausea/vomiting</td>
</tr>
<tr>
<td>weight loss/gain</td>
</tr>
<tr>
<td>difficulty maintaining balance while walking</td>
</tr>
<tr>
<td>falls</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you EVER been diagnosed with any of the following conditions (check all that apply)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>cancer</td>
</tr>
<tr>
<td>heart problems</td>
</tr>
<tr>
<td>chest pain/angina</td>
</tr>
<tr>
<td>high blood pressure</td>
</tr>
<tr>
<td>circulation problems</td>
</tr>
<tr>
<td>blood clots</td>
</tr>
<tr>
<td>stroke</td>
</tr>
<tr>
<td>anemia</td>
</tr>
<tr>
<td>bone/joint infection</td>
</tr>
<tr>
<td>chemical dependency (e.g., alcoholism)</td>
</tr>
</tbody>
</table>

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

| cancer | diabetes | tuberculosis |
| heart problems | stroke | thyroid problems |
| high blood pressure | depression | blood clots |

During the past month have you been feeling down, depressed or hopeless? YES  NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES  NO

Is this something with which you would like help? YES  YES, BUT NOT TODAY  NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES  NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ___________________________  2. ___________________________  3. ___________________________

4. ___________________________  5. ___________________________  6. ___________________________

Have you ever taken steroid medications for any medical conditions? YES  NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES  NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. ___________________________  2. ___________________________  3. ___________________________
What date (roughly) did your present symptoms start? __________________________________________

What do you think caused your symptoms? ________________________________________________

My symptoms are currently: ___ Getting Better ___ Getting Worse ___ Staying about the same

I should not do physical activities that might make my pain worse: ___ Disagree ___ Unsure ___ Agree

Treatment received so far for this problem (chiropractic, injections, etc) _______________________

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____________________

Have you ever had this problem before: ___ Yes ___ No When ________ Treatment rec’d ________

How long did it take for you to feel better? ________________________________________________

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right:

<table>
<thead>
<tr>
<th>My symptoms currently: ___ Come and go ___ Are Constant ___ Are constant, but change with activity</th>
</tr>
</thead>
</table>

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. __________________________________________
2. __________________________________________
3. __________________________________________

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. __________________________________________
2. __________________________________________
3. __________________________________________

How are you currently able to sleep at night due to your symptoms?

___ No problems sleeping ___ Difficulty falling asleep ___ Awakened by pain ___ Sleep only with medication

When are your symptoms worst:

___ Morning ___ Afternoon ___ Night ___ After exercise

When are your symptoms the best:

___ Morning ___ Afternoon ___ Night ___ After exercise

Using the 0 to 10 scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

Your current level of pain while completing this survey: _________

The best your pain has been during the past 24 hours: _________

The worst your pain has been during the past 24 hours: _________
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL DUTY
Collins Physical Therapy Institute is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION
Collins Physical Therapy Institute uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Collins Physical Therapy Institute may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Because of the close proximity of treatment areas at Collins Physical Therapy Institute, it may be possible for other patients to overhear your treatment plan or other personal information about your condition. Private treatment rooms are available upon request.

Collins Physical Therapy Institute may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT’S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances.

CONCERNS AND COMPLAINTS
If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Practice Manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

Jackie Augustine
800 Goodlette RdN,Ste 140, Naples, FL 32102
Tel: 239-384-5952 Fax: 239-384-5970

****Please retain this copy for your records****