MAC
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Please fill out this form completely. If you have any questions, please feel free to ask, we are happy to assist you.

Patient Information

Name: Last_____ First _____ MI_____

Preferred Name (nickname) _____ DOB _____ □ Male □ Female

Address _____ City _____ State _____ Zip _____

Employer _____ □ Single □ Married □ Other

Phone: H _____ C _____ W _____

E-mail _____ Preferred Method of contact: □ Phone □ Email

Emergency Contact: Name _____ Relationship _____ Phone # _____

Physician Information

Referring Physician _____

Primary Care Physician _____

Diagnosis _____

Have you had Surgery? Y____ N____ If yes when? _____

Is the injury a result of an accident?

Auto_____ Work_____ Other_____ Date of Injury_____

How Did You Hear About Us:

□ Referred by Friend or Family
□ Referred by Physician
□ Social Media
□ Attended Workshop
□ Internet Search
□ I was a previous patient
□ Other - _____

Insurance Information

Insurance Company _____ ID Number _____ Group #_____

Policy Holder: Last_____ First _____ MI_____ DOB _____

Relationship to Patient_____ Phone: H_____ C_____

Address of Insured (if different than above)

Street _____ City _____ State _____ Zip _____

Secondary Insurance? Y_____ N_____

If so: Insurance Company _____ ID # _____ Group #_____

Policy Holder: Last_____ First _____ MI_____ DOB _____

Relationship to Patient_____ Phone: H_____ C_____

Address of Insured (if different than above)

Street _____ City _____ State _____ Zip _____

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Patient Name_____ DOB _____ Height _____ Weight _____

Injury Onset Date: _____ Referring Physician: _____

Description of how the injury occurred: _____

_____

Please list any treatment received for current condition:

_____

_____

Did you have Surgery? Yes / No

If Yes, what Surgery did you have? _____

Date of Surgery? _____

Pain at LOWEST: Rate your lowest pain level in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain Imaginable

Pain CURRENTLY: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10

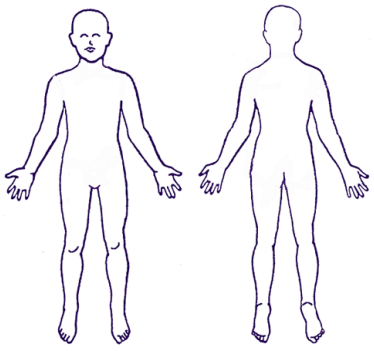
No pain — Worst pain Imaginable

Pain at WORST: Rate your highest pain level in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain Imaginable

Body Chart:
Please circle the location of your pain or injury.



What makes the pain worse? _____

What makes the pain Better? _____

Are you Currently Experiencing Any of the Following Symptoms? (Check all that apply)

- □ changes in bowl or bladder function
- □ fever / chills / sweats
- □ shortness of breath
- □ dizziness / lightheadedness
- □ weakness / fatigue
- □ changes in appetite
- □ difficulty with hearing or vision
- □ weight loss / gain
- □ nausea / vomiting
- □ numbness / tingling
- □ headaches
- □ difficulty maintaining balance
- □ difficulty swallowing
- □ difficulty sleeping

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MEDICAL HISTORY (Check all that apply)

- □ Alzheimer's
- □ Cardiovascular Disease
- □ Cauda Equina Syndrome
- □ Current Infection
- □ Diabetes Type I
- □ Diabetes Type 2
- □ Fibromyalgia
- □ Fracture
- □ High Blood Pressure
- □ History of Cancer
- □ Immunosuppression
- □ Lupus
- □ Muscular Dystrophy
- □ Obesity
- □ Osteoarthritis
- □ Parkinson's Disease
- □ Rheumatoid Arthritis
- □ Traumatic Brain Injury
- □ Other _____

Allergies:

_____

_____

_____

_____

Medications with Dosages:

_____

_____

_____

_____

Please list and date all surgeries and hospitalizations:

_____

_____

_____

Are you currently pregnant or think you might be pregnant? Y_____ N_____

Do you smoke? Y_____ N_____

What is your goal for physical therapy? _____

_____

_____

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Informed Consent for the Physical Therapy Patient

MAC Physical Therapy Group LLC expects physical therapists to ensure that the patient/client or responsible party (parent, spouse, guardian, caregiver, etc.) has given appropriate consent before any physical therapy is undertaken.

Informed consent is based on the moral and legal premise of patient/client autonomy, whereby a patient's/client's decision to participate in examination/assessment, evaluation, diagnosis, prognosis/plan, intervention/treatment and re-examination, as well as in any research activity, is freely given by a competent individual: who has received the necessary information; who has adequately understood the information; and who, after considering the information, has arrived at a decision without having been subjected to coercion, undue influence, inducement, or intimidation.

Patients/clients have the right to make decisions about their own participation in examination/assessment, evaluation, diagnosis, prognosis/plan, intervention/treatment, re-examination, as well as in any research, without their physical therapist trying to influence the decision. Patient autonomy does allow for physical therapists to educate the patient/client, but does not allow the physical therapist to make the decision for the patient/client. Informed consent protects the individual's freedom of choice and respects the individual's autonomy.

Competent individuals should be provided with adequate, intelligible information about the proposed physical therapy. This information should include a clear explanation of the examination, evaluation, treatment, diagnosis, prognosis, length of treatment and cost.

The physical therapist should ascertain the ability of the patient/client to understand the above before seeking consent. When the individual is not deemed competent or when the patient/client is a minor, a legal guardian or advocate may act as a surrogate decision-maker.

Physical therapists should record in their documentation that informed consent has been obtained.

Physical therapists working in team situations are responsible for ensuring that appropriate consent arrangements have been made prior to any examination/assessment, intervention or research. While another member of the team may acquire the consent, it does not negate the physical therapist's responsibility for ensuring that the patient/client is properly informed about the physical therapy service to be rendered.

MAC Physical Therapy Group LLC require all their employees to:

- physical therapists comply with all national and local legal and procedural requirements for informed consent
- the responsibility of the physical therapist in relation to informed consent is an essential component of entry level professional physical therapist education programs
- the responsibility of the physical therapist in relation to informed consent is included in professional standards, codes of conduct and ethical principles

NOTICE OF PRIVACY PRACTICES

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

The terms of this Notice of Privacy Practices apply to Select Medical Corporation and each of its subsidiaries, affiliates, and entities managed or controlled by Select Medical, including the corporate office and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. Use or disclosure pursuant to this Notice may include electronic transmittal or disclosure of your personal health information.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Select Medical Corporation. Should we make a change, you may obtain a revised copy from the location providing treatment. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer, Select Medical Corporation, P.O. Box 2034, Mechanicsburg, PA 17055.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

A. Uses and Disclosures That May Be Made Without Your Consent

Uses and Disclosures for Treatment: We may make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

Uses and Disclosures for Payment: We may make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We may use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you, to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Privacy Officer, P.O. Box 2034, Mechanicsburg, PA 17055.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law;
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations;
- if we suspect child abuse or neglect;
- if we believe you to be a victim of abuse, neglect, or domestic violence;
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- in response to a court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military we may also release your personal health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

B. Uses and Disclosures That May Be Made Either With Your Authorization or the Opportunity to Object

Individuals Involved In Your Care: Unless you object, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for

your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

C. Uses and Disclosures Based Upon Your Written Authorization
Psychotherapy Notes: We must obtain your written authorization for most uses and disclosures of psychotherapy notes.

Marketing: We must obtain your written authorization to use and disclose your personal health information for most marketing purposes.

Sale of Personal Health Information: We must obtain your written authorization for any disclosure of your personal health information which constitutes a sale of personal health information.

Other Uses: Other uses and disclosures of your personal health information, not described above, will be made only with your written authorization. You may revoke your authorization, at any time, in writing, except to the extent that we have taken action in reliance on the authorization.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION
Access to Your Personal Health Information: You have the right to a copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. If you request a copy of your personal health information you may be charged a nominal fee for copying and postage.

Amendments to Your Personal Health Information: You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information: You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free. You will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will

attempt to accommodate reasonable requests when appropriate. However, we must agree not to disclose your personal health information to your health plan if the disclosure is for payment or health care operations and relates to a health care item or service which you paid for in full out of pocket. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Receive Confidential Communications From Us by Alternative Means or at Alternative Locations: You have the right to request that we communicate with you in a certain way or at a certain location. Your request must be in writing and specify how and where you would like to be contacted. We will accommodate all reasonable requests.

Paper Copy: You have the right to obtain a paper copy of this notice from us.

Breaches of Unsecured Personal Health Information: You have the right to be notified if you are affected by a breach of unsecured personal health information.

Workers' Compensation: For patients whose medical treatment is covered under a state workers' compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state's workers' compensation is governed by the state workers' compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPAA in order to disclose your PHI for workers' compensation purposes, nor may you restrict our use or disclosure of your PHI for workers' compensation purposes. Written consent to use or disclose your PHI may be required pursuant to our internal policies and/or state workers' compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, Select Medical Corporation, P.O. Box 2034, Mechanicsburg, PA 17055. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions, need further assistance regarding this Notice, or wish to file a complaint you may contact The US Department of Health and Human Services Office of Civil Rights. 200 Independence Ave., SW. Washington, DC 20201. T:202.619.0257. toll free: 877.696.6775

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Office Policy

Adult patients or in the case of a patient who is a minor, the parent who brings the child patient to scheduled appointments, shall be deemed the responsible party. It is understood and agreed that the party signing the contract is solely responsible for the patient's account. Financial arrangements between divorced parents or a third party are outside the domain of the arrangements with this office.

General Information

- The Copay is expected to be paid prior to services being rendered.
- If you arrive more than 10 minutes late for your appointment, we will have to evaluate our schedule for that day before we can commit to seeing you. You may have to be rescheduled on another day.
- Notice of at least 24 hours for an appointment change is appreciated as this time is reserved for you. If you do miss your appointment, it will be your responsibility to reschedule. We reserve the right to charge $50.00 for a broken appointment with less than 24 hours-notice.
- If transfer to another therapy office is necessary, your balance must be paid prior to release of records to other office. Our office must retain a copy of the records for any patient treated; there will be a fee for duplication of these records for transfer.
- MAC Physical Therapy Group participates with most major insurance plans. It will be your responsibility to check your insurance benefit and see if you require authorization for physical therapy. You will be responsible for an amount based on your insurance program coverage.

Agreement

- I have been provided with a copy of the following and understand them to my satisfaction:
  - **a.** Informed Consent _____**Please Initial**
  - **b.** Notice of Privacy Practices _____ **Please Initial**

- I hereby consent physical therapy evaluation and treatment by the professional staff and MAC Physical Therapy Group. I fully understand all of the risks associated with the treatment. _____**Please Initial**

- If patient is under 18, I (parent) give permission for my child to be treated by the physical therapists without me being present. _____**Please Initial**

- I give MAC Physical Therapy Group LLC permission to use my name and images/videos of myself in marketing and promotional materials. _____**Please Initial**

- ***RELEASE OF PATIENT INFORMATION****:* I hereby authorize the doctor(s) to provide other health care providers with information regarding the above individual's care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information. _____**Please Initial**

Patient: _____Parent/Guardian (print): _____

Signature: _____ Date: _____