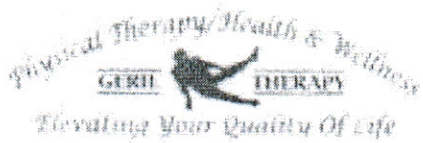

GERIL THERAPY
PATIENT INFORMATON FORM

NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: ( )_____ WORK: ( )_____ CELL: ( )_____

E-MAIL ADDRESS:_____

SOCIAL SECURITY #_____

DATE OF BIRTH:_____ SEX: M or F MARITAL STATUS: M S D W U

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN:_____ PHONE #: ( )_____

EMERGENCY CONTACT INFORMATION:

NAME:_____ RELATIONSHIP:_____

PHONE#:_____

ACCIDENT/SURGICAL INFORMATION:

SURGERY? Y or N DATE OF SURGERY:_____ TYPE OF SURGERY:_____

ACCIDENT TYPE: N/A W/C AUTO OTHER ACCIDENT/INJURY/ONSET DATE:_____

TYPE OF ACCIDENT/INJURY:_____

HOME HEALTH IN THE LAST 6 MONTHS? Y or N

Geril Therapy
Consent For Treatment

I, the undersigned, a patient at Geril Therapy, do hereby authorize GERIL THERAPY, and whoever they designate a therapist or assistant to administer treatment as necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that as a courtesy GERIL THERAPY will prepare insurance forms and bill my insurance company directly.
I hereby request assignment of payment of all insurance benefits to GERIL THERAPY. I am ultimately responsible for payment of all services rendered, unless otherwise provided by law.

Deductibles/Percentage pays and/or Co-Payments

Co-payments are to be paid at time of service, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the date on the invoice. Patients are to keep payments current.

Cancellations/No-Show Policy

I understand that cancellations should be made within 24 hours prior of the scheduled appointment time, unless extenuating circumstances prevent otherwise. A $50 fee may be enforced for no shows or late cancellations. Three (3) no show/cancellations may result in discharge from care. I understand if I am discharged from care for non-compliance, future referrals for physical therapy may not be accepted.

By signing below, you are agreeing to all of the above terms and conditions. Additionally, I confirm that I have received a copy of GERIL THERAPY's Privacy Practices.

Patient or Legal Guardian's Signature/ Date

Witness Signature/ Date

PATIENT AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

GERIL THERAPY

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to re-disclosure by the recipients and no longer be protected by federal privacy regulations.
PATIENT:_____DATE OF BIRTH:_____

Persons/organizations providing the information:

_____
_____

Specific description of information (including date(s)): _____
_____
_____
_____

What is the purpose of use or disclosure of patient information?: _____
_____
_____

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on ____/____/_____ (DD/MM/YEAR) Initials:
If I fail to specify an expiration date, this authorization will expire 12 months from the date signed _____ or after this event.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions the Provider Organization performed before it received the revocation. Initials:

3. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

If a patient's representative signs this authorization, please complete the following:

_____
Printed name of patient's representative:

_____
Relationship to the patient:

Describe the representative's authority to act for the patient:
_____
_____
_____

Created: 7/6/06
Effective: 7/6/06
Approved by: AG

Physical Therapy, Health & Wellness
GERE THERAPY
Elevating Your Quality Of Life

FAMILY/PERSONAL HISTORY Date: _____

Client's Name: _____ DOB: _____ Age: _____

Race/ethnicity:
- □ American Indian/Alaska Native
- □ Asian
- □ Black/African American
- □ Caucasian/white
- □ Hispanic/Latino
- □ Native Hawaiian/Pacific Islander
- □ Multi-racial
- □ Other/unknown

Language:
- □ English understood
- □ Interpreter needed
- □ Primary language:

Medical Diagnosis: _____ Date of onset: _____

Physician: _____ Date of surgery (if any): _____ Therapist: _____

Personal History

Have you ever had:

• Anemia	Yes	No	• Chronic bronchitis	Yes	No
• Epilepsy/seizures	Yes	No	• Emphysema	Yes	No
• Fibromyalgia/myofascial pain syndrome	Yes	No	• GERD	Yes	No
			• Gout	Yes	No
• Hepatitis/jaundice	Yes	No	• Guillain-Barré Syndrome	Yes	No
• Hypoglycemia	Yes	No	• Parkinson's disease	Yes	No
• Joint replacement	Yes	No	• Peripheral vascular disease	Yes	No
• Polio/postpolio	Yes	No	• Pneumonia	Yes	No
• Shortness of breath	Yes	No	• Prostate problems	Yes	No
• Skin problems	Yes	No			
• Rheumatic/scarlet fever	Yes	No	• Thyroid problems	Yes	No
• Urinary incontinence problems (dribbling, leaking)	Yes	No	• Ulcer/stomach		
	Yes	No			
• Urinary tract infection	Yes	No			
• Varicose veins	Yes	No			

For women:

History of endometriosis	Yes	No
History of pelvic inflammatory disease	Yes	No
Are you/could you be pregnant?	Yes	No
Any trouble with leaking or dribbling urine?	Yes	No
Number of pregnancies _____	Number of live births _____	
Have you ever had a miscarriage/abortion?	Yes	No

General Health

1. I would rate my health as (circle one): Excellent Good Fair Poor
2. Are you taking any **prescription** or over-the-counter medications? Yes No
   IF YES, PLEASE LIST ON SEPARATE SHEET:
3. Are you taking any nutritional supplements (any kind, including vitamins) IF YES, PLEASE LIST ON SEPARATE SHEET: Yes No
4. Have you had any illnesses within the last 3 weeks (e.g., colds, influenza, bladder or kidney infection)? Yes No
   If yes, have you had this before in the last 3 months? Yes No
5. Have you noticed any lumps or thickening of skin or muscle anywhere on your body? Yes No
6. Do you have any sores that have not healed or any changes in size, shape, or color of a wart or mole? Yes No
7. Have you had any unexplained weight gain or loss in the last month? Yes No
8. Do you smoke or chew tobacco? Yes No
   If yes, how many packs/pipes/pouches/sticks a day? _____
   How many months or years? _____
9. I used to smoke/chew but I quit Yes No
   If yes: pack or amount/day _____ Year quit _____
10. I would like to quit smoking/using tobacco Yes No
11. How much alcohol do you drink in the course of a week? (one drink is equal to 1 beer, 1 glass of wine or 1 shot of hard liquor) _____
12. Do you use recreational or street drugs (marijuana, cocaine, crack, meth, amphetamines, or others)? If yes, what, how much, how often? _____ Yes No
    _____
13. How much caffeine do you consume daily (including soft drinks, coffee, tea, or chocolate)? _____
14. Are you on any special diet? Yes No
15. Do you have (or have you recently had) any of these problems:

□ Blood in urine, stool, vomit, mucous	□ Cough	□ Difficulty swallowing/speaking
□ Dizziness, fainting, blackouts	□ Dribbling or leaking urine	□ Memory loss
□ Fever, chills, sweats (day or night)	□ Heart palpitations or fluttering	□ Confusion
□ Nausea, vomiting, loss of appetite	□ Numbness or tingling	□ Sudden weakness
□ Changes in bowel or bladder	□ Swelling or lumps anywhere	□ Trouble sleeping
□ Throbbing sensation/pain in belly or anywhere else	□ Problems seeing or hearing	
□ Skin rash or other changes	□ Unusual fatigue, drowsiness	□ None of these

Medical/Surgical History

1. Have you ever been treated with chemotherapy, radiation therapy, biotherapy, or brachytherapy (radiation implants)? Yes No
   If yes, please describe:
2. Have you had any x-rays, sonograms, computed tomography (CT) scans, or magnetic resonance imaging (MRI) or other imaging done recently? Yes No
   If yes, what? When? Results?
3. Have you had any laboratory work done recently (urinalysis or blood tests)? Yes No
   If yes, what? When? Results (if known)?
4. Any other clinical tests? Yes No
   Please describe:
5. Please list any operations that you have ever had and the date(s):
   Operation Date
6. Do you have a pacemaker, transplanted organ, joint replacement, breast implants, or any other implants? Yes No
   If yes, please describe:
7. Are you aware of what your diagnosis is? Yes No
8. Do you have any problems taking care of your self independently at home, or feel that you need to speak to a social worker? Yes No

Physical Therapy, Health & Wellness
GERH THERAPY
Elevating Your Quality Of Life

Past Medical History

Have you or any immediate family member (parent, sibling, child) ever been told you have:

skip

(Do **NOT** complete) **For the therapist:**

Circle one:			Relation to Client	Date of Onset	Current Status
• Allergies	Yes	No			
• Angina or chest pain	Yes	No			
• Anxiety/Panic attacks	Yes	No			
• Arthritis	Yes	No			
• Asthma, hay fever, or other breathing problems	Yes	No			
• Cancer	Yes	No			
• Chemical dependency (alcohol/drugs)	Yes	No			
• Cirrhosis/liver disease	Yes	No			
• Depression	Yes	No			
• Diabetes	Yes	No			
• Eating disorder (bulimia, anorexia)	Yes	No			
• Headaches	Yes	No			
• Heart attack	Yes	No			
• Hemophilia/slow healing	Yes	No			
• High cholesterol	Yes	No			
• Hypertension or high	Yes	No			
blood pressure	Yes	No			
• Kidney disease/stones	Yes	No			
• Multiple sclerosis	Yes	No			
• Osteoporosis	Yes	No			
• Stroke	Yes	No			
• Tuberculosis	Yes	No			
• Other (please describe)	Yes	No			
	Yes	No			
	Yes	No			
	Yes	No			

Work/Living Environment

1. What is your job or occupation? _____
2. Military service: (When and where): _____
3. Does your work involve: □ Prolonged sitting (e.g., desk, computer, driving)
   □ Prolonged standing (e.g., equipment operator, sale clerk)
   □ Prolonged walking (e.g., mill worker, delivery service)
   □ Use of large or small equipment (e.g., telephone, forklift, computer, drill press, cash register)
   □ Lifting, bending, twisting, climbing, turning
   □ Exposure to chemicals, pesticides, toxins, or gases
   □ Other: please describe
   □ Not applicable; none of these
4. Do you use any special supports: □ Back cushion, neck cushion
   □ Back brace, corset
   □ Other kind of brace or support for any body part
   □ None; not applicable

History of falls:
□ In the past year, I have had no falls.
□ I have just started to lose my balance/fall.
□ I fall occasionally.
□ I fall frequently (more than two times during the past 6 months).
□ Certain factors make me cautious (e.g., curbs, ice, stairs, getting in and out of the tub).

I live:
□ Alone □ With family, spouse, partner
□ Nursing home □ Assisted Living □ Other _____

For the physical therapist:

Vital Signs

Resting pulse rate: Oral temperature:
Respirations: Oxygen saturation:
Blood pressure: 1st reading _____ 2nd reading _____
Position: Sitting Standing Extremity: Right Left

Physical Therapy/Health & Wellness
GURU THERAPY
Elevating Your Quality Of Life

CURRRENT MEDICATIONS/ VITAMINS:

MEDICATION	DOSAGE	FREQUENCY	PLEASE INITIAL

Therapists: Use this space to record baseline information. This is important in case something changes in the client's status. You are advised to record the date and sign or initial this form for documentation and liability purposes, indicating that you have reviewed this form with the client. You may want to have the client sign and date it as well.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF

GERIL THERAPY

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 **Adam Geril, MS, PT, OCS, ATC.** of our office at **352-342-236-1811, 4901 East Silver Springs Blvd., Suite 305 SIX GUN PLAZA Ocala, FL 34470**

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. for example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to **Adam Geril, MS, PT, OCS, ATC** in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to **Adam Geril, MS, PT, OCS, ATC**. It must state a time period, which may not be longer than six years and may not include dates before April 19, 2006. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *a Request For Restricting Uses and Disclosures and Confidential Communications Form* Information to **Adam Geril, MS, PT, OCS, ATC.**

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit *the Requests For Restricting Uses and Disclosures and Confidential Communications* to **Adam Geril, MS, PT, OCS, ATC.**
]. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact **Adam Geril, MS, PT, OCS, ATC.**

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact **Adam Geril, MS, PT, OCS, ATC.**
. You will not be penalized for filing a complaint.