ProBalance Inc.
Physical Therapy * Sports Rehab * Pilates

2213 Harbor Bay Pkwy
Alameda, CA 94502

## NEW CLIENT/PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Contact Information | Name | | Age | Date of Birth | ❑ Male ❑ Female |
| | Home Phone: | Best phone number to reach me: | Email | | |
| | Street Address | | City | | State & Zip |
| | Employer Name | | Occupation | | Work Phone |
| | Emergency Contact Name or Nearest Relative | | Relationship | | Emergency Phone |
| | | | | | |
| For PT | I will be submitting my receipts to my health insurance or Flexspend? ❑ Yes ❑ No | I have a referral from my MD, DC, DO, DPM, etc. for treatment? ❑ Yes ❑ No | Referring physician or chiropractor | | |
| | How did you hear about us? Circle all that apply:<br>Friend/Family :_____ MD referral_____Internet Search Newspaper Yelp Facebook/Twitter PhoneBook<br>Golf Pro/Coach/Trainer:_____Alameda Magazine Gull's Call BFMG APN BPN Other:_____ | | | | |

## SELF-PAY, FINANCIAL, AND CANCELLATION POLICIES

We take pride in the high-level quality of our services and operate on a different model and level than traditional physical therapy clinics and regular fitness Pilates studios. In order to provide you with the best possible experience, please read the following policies, initial, and sign below to acknowledge our policies.

- _____**(initials)** Payment for services is due at the time services are rendered. (Cash, Check, or Credit Card)
- _____**(initials)** **A credit card will be kept on file** that is authorized to pay for the day's service, cancellation fees, or for any unpaid balance for your session. **You authorize ProBalance, Inc. to charge your credit card on file for unpaid services received unless prior arrangements have been made in writing.***
  *_____**(initials)** In the event you choose *not* to keep a credit card on file, you may make a payment in person or by phone. *However,* if we do not receive payment *on the day of service*, you may be charged an additional $35 late payment fee on top of the balanced owed.
- _____**(initials)** A minimum cancellation fee of $35 will be charged for cancellations/no shows less than 24 hours advance notice for appointments and less than 12 hours for classes (class price will be charged/deducted). *Note: Practitioners at ProBalance reserve the right to charge **up to the full price of the visit** for late cancellations/no-shows.*
- _____**(initials)** Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 3% per month.
- _____**(initials)** Unused wellness/fitness packages are cash refundable within 14 days of purchase; otherwise, they may be ONLY be exchanged for service credit to your ProBalance account. **Packages may not be exchanged for a different package/service once at least one session has been used and/or if the expiration date has been exceeded.*
- _____**(initials)** Wellness/Fitness/Preventative services (classes &/or private sessions) performed by physical therapists may not be submitted to health insurance or Medicare for reimbursement.
- _____**(initials)** All wellness/fitness packages have expiration dates. All class packages have an expiration date of 6 months from first use and all private fitness/wellness sessions expire 12 months from first use.

I have read and agree to the policies mentioned above.

_____ _____ ___/___/20___
Patient Name Signature Today's Date

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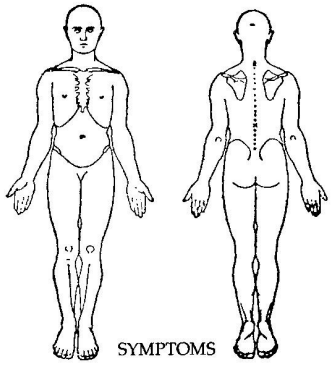
# Pre-Screening Health Questionnaire

1. What are your goals? (i.e. why are you here, what activities would you like to return to or improve, etc.)

2. Do you have pain or a physical condition which is currently limiting you? · Yes · No (if no, skip to #4) ·
   2a. When did this problem/pain first begin? _____
   2b. Are you currently under the direct care of a medical professional? · No · Yes (who)_____
   2c. Recent Surgery Date?_____What Procedure? _____

3. Indicate on the chart to the right if you are experiencing any pain/symptoms.




3a. Do you have any numbness or tingling? · Yes · No
3b. Do you have pain with coughing/sneezing? · Yes · No
3c. On a scale from 1 to 10, my worst recent pain has been ____/10.

*Mild discomfort* *Moderate* *Unbearable, Severe*
1----------5----------10

3d. I have pain that bothers me:
· constantly · most of the time · only occasionally · once in a while · with certain movements
3e. Symptoms are worse with:_____
3f. Symptoms are better with:_____

4. Circle and/or list all medical conditions you have or have had:

____Cancer
____Pacemaker
____High Blood Pressure
____Diabetes
____Heart disease
____Glaucoma
____Gastric Reflux
____Vertigo or Dizziness
____Other (describe):_____

____Osteoporosis/Osteopenia (low bone density)
____Osteo-arthritis (degenerative joints)
____Rheumatoid Arthritis
____Stenosis or Spondylolisthesis
____Sciatica or radiating pain down leg
____Radiating pain down arm or leg
____Herniated Disc (where/when?)_____
____ Neurologic disease or paralysis_____

____Currently Pregnant (How many weeks?)
____Post-partum <1 yr
____Currently Breastfeeding
_____Pelvic instability or SI joint problems
_____ Headaches

5. Have you had any surgeries? · No · Yes (If yes, list dates/types/details of surgeries below):

____Total Hip Replacement(s)_____
____Total Knee Replacement(s)_____
____Spinal Surgery_____
____Shoulder Surgery_____
____C-Section_____
____Mastectomy/lumpectomy_____
____Other abdominal surgeries_____
____Other Upper Extremity Surgeries (hand, elbow, wrist)_____
____Other Lower Extremity Surgeries (hip, knee, foot/ankle)_____
____Other:_____

8a. Have you done Pilates or another movement focused exercise program before? · Yes · No

8b. Do you currently exercise on a regular basis? If yes, describe your current workout or exercise routine.

_____ _____ ___/___/20___
Patient Name Signature Today's Date

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# 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 IT CAREFULLY.

ProBalance, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

**Disclosure of Your Health Care Information**

**Treatment**
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. We are a teaching facility so there may be students observing treatments for their respective professional programs. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with ProBalance, Inc.

> *"It is our policy to provide a substitute health care provider, authorized by ProBalance, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

**Payment**
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

> "*As a courtesy to our physical therapy patients, we provide may provide an itemized billing statement to you to submit to your insurance carrier for the purpose of reimbursement for qualifying health care services rendered. The billing statement contains medical information, including diagnosis and codes which describe the health care services received."*

**Electronic Communication**
Much of our communication is via electronic means, including online scheduling software. Your information is not shared with third parties as is used to facilitate communication between practitioners & clients/patients. Please be assured that every step is taken to ensure the confidentiality of your health information, included password protected computers and accounts in accordance with HIPAA requirements.

**Emergencies**
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

**Public Health**
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings.**
We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement.**
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons**.
We may disclose your health information to coroners or medical examiners.

**Organ Donation.**
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Research.**
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

**Teaching Facility**
We are a teaching facility so there periodically may be students observing your session or class. Please be assured that they are required to adhere to this published privacy policy.

**Public Safety.**
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

**Specialized Government Agencies.**
We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Change of Ownership.**
In the event that ProBalance, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

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**Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that ProBalance, Inc. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. Note that there may be administrative/records fees associated with acquisition/copying of records.
- You have the right to inspect and copy your health information.
- You have a right to request that ProBalance, Inc. amend your protected health information. Please be advised, however, that ProBalance, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by ProBalance, Inc..
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

ProBalance, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, ProBalance, Inc. is required by law to comply with this Notice.

ProBalance, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Ada Wells by calling this office at (510) 523-1900. If Ada Wells is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints**

Complaints about your Privacy rights, or how ProBalance, Inc. has handled your health information should be directed to Ada Wells by calling this office at (510) 523-1900. If Ada Wells is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of July 1st, 2008.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide ProBalance, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice and I have received a copy or have access to an electronic copy of this form.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

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# Release of Liability/Informed Consent

I desire to engage voluntarily in ProBalance Inc.'s Physical Therapy/Pilates/Wellness Program(s). In order to attempt to improve my physical condition, I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory and musculoskeletal systems and thereby attempt to improve their function. The reaction of the cardiorespiratory and musculoskeletal systems cannot be predicted with complete accuracy. These changes might include abnormalities in blood pressure and heart rate, injury to the connective tissue and musculoskeletal systems potentially resulting in stroke, heart attack, permanent injury and possibly death.

The use of all ProBalance facilities – exercise equipment including Pilates apparatus, props, weights, treadmills, and stationary cycles– is undertaken by the patient/client at his/her sole risk. The risk of injury from activities involved in this program is significant, including the potential for permanent paralysis and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist.

All of ProBalance Inc.'s Staff/Contractors are professionally licensed or comprehensively trained in their respective fields. I understand that I am responsible for informing ProBalance Representatives/Staff of any known physical limitations, illnesses, or other physical conditions. Should any unusual symptoms occur during my time at the ProBalance Studio facilities, I will inform a ProBalance representative/staff member immediately. In addition, if I experience a change in my physical limitations, illnesses or other physical conditions or become ill outside the ProBalance Studio facility I will inform a representative/staff member of this change prior to resuming treatment and/or workouts on my next visit and/or contact my doctor if the symptoms warrant. I have consulted my physician before participation in these programs and hereby represent to ProBalance, Inc. that I have their approval to engage in such activities.

ProBalance, Inc. is a teaching facility and on occasion, there may be students observing patient/client sessions as it pertains to their educational requirements. There may also be interns and apprentice teachers assisting under the direct supervision of a qualified practitioner.

I willingly agree to comply with the stated and customary terms and conditions for participation. If, however I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest ProBalance representative/staff member immediately

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless ProBalance, Inc., their officers, officials, agents, independent contractors, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("Releasees"), with respect to all and any injury, disability, death, or loss or damage to person or property, whether arising from the negligence of the releasees or otherwise, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY/CONSENT FORM AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

_____ _____

PARTICIPANT'S SIGNATURE DATE

***Please initial here_____ to indicate that you have received a copy of this consent form or have been informed as to where to find this form on our website at www.ProBalancePT.com.***

**********

*FOR PARENTS/GUARDIANS OF PARTICIPANTS OF MINORITYAGE*
*(UNDER AGE 18 AT TIME OF REGISTRATION)*

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release, as provided above, of all the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, even if arising from their negligence, to the fullest extent permitted by law.

_____ _____

PARENT/GUARDIAN'S SIGNATURE DATE

EMERGENCY PHONE:_____Relationship_____