The ExerScience Center

24706 State Road 54
Lutz, FL 33559
Phone: (813) 803-7070

Patient Information Sheet

Name: _____ **Date of Birth:** _____

Home Phone:_____ **Cell Phone:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____ **SSN:**_____

Emergency Contact: _____ **Phone:** _____

Insurance Carrier: _____ **Phone Number:**_____

Member ID:_____ **Group Number:**_____

Policy Holder:_____ **Date of Birth(policy holder):**_____

Physician(first & last): _____ **Phone:**_____

Diagnosis:_____

Patient Information release Authorization and Assignment of Insurance Benefits

Please be aware that all medical information is confidential under certain state and federal laws. Such information is may not be released without your consent. Many insurance carriers require medical information to be submitted with claims to evaluate medical necessity. Please provide your written consent to release related information when required or requested to your insurance company(s) and/or your healthcare team.

I,_____, do hereby authorize The ExerScience Center, to acquire from and/or release to my healthcare team and /or my insurance company(s), any information required for the purposes of healthcare management and/or for processing all medical claims on my behalf. I understand that upon acceptance of treatment from The ExerScience Center, I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I authorize The ExerScience Center to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to The ExerScience Center. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to The ExerScience Center. I have read and completed this form and certify that all the above information is correct to the best of my knowledge.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent (if patient is a minor) **Date**

The ExerScience Center

PATIENT NAME:_____

MEDICAL HISTORY / BODY / PAIN CHART AND ADL SCREEN

Diagnosis as stated to you by your physician: _____ Date of onset? _____
How did this injury/exacerbation occur? _____
Have you been hospitalized for the present condition? ☐ Yes ☐ No If Yes, Date: _____
Have you had surgery for the present condition? ☐ Yes ☐ No If Yes, Date: _____
Have you received previous treatment for this condition? ☐ Yes ☐ No If Yes, Date: _____
If Yes, please summarize: _____
Are you currently receiving or have you received in the last 30 days any other home health, medical or chiropractic services rendered to you by any other agency, organization or individual? If yes, please summarize:

_____

Are you on medications? Please list (you may use back of page) _____
Have you ever had any of the following? ☐ EMG ☐ CAT SCAN ☐ MYELOGRAM ☐ MRI ☐ XRAY

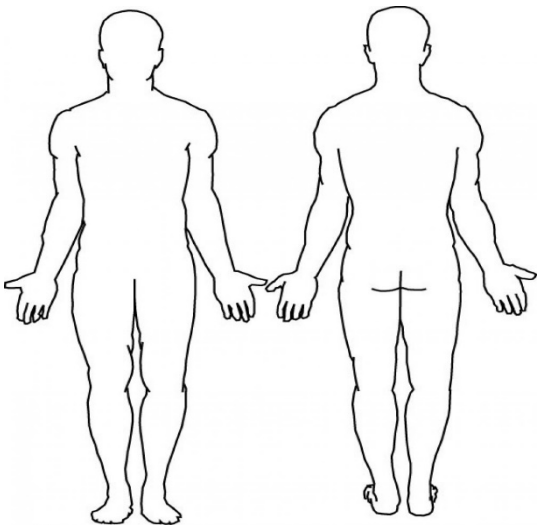
Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Pregnancy	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Back Injury	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Fracture	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Metalology (implants)	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis A, B, C	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
list:		
Other:		

Please circle all that may apply. My pain is worse:
in the morning / during the day / at night / with activity / during rest

On a scale of 0 – 10,
(0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best _____ and at its worst _____

Using the key provided below, please draw the symbol representing your pain over the area of the body as it relates to your present condition.



Key

↓ or ↑ Radiating Pain
XXX Spasm
ZZZ Tenderness
/// Numbness
*** Tingling
000 Aches / Pain

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? Check all that apply.

☐ Getting in/out of bed
☐ Getting in/out of a car
☐ Getting in/out of a chair
☐ Walking up/down the stairs
☐ Getting in/out of the shower
☐ Other: _____

☐ Personal hygiene activities
☐ Bathing/Shower
☐ Brushing teeth
☐ Dressing
☐ Work Activities

☐ Eating
☐ Sleeping
☐ Sitting
☐ Standing
☐ Walking

☐ Shaving
☐ Lifting
☐ Cooking
☐ Laundry
☐ Driving

☐ Cleaning
☐ Writing
☐ Shopping
☐ Vacuuming

Patient's Signature: _____ Date: _____/_____/_____

I have reviewed the above information

Therapist Signature: _____ Date: _____/_____/_____

The ExerScience Center

Communication Policy

Opt-In for Email and Text Communications

You may opt-in to receiving emails and texts as described below. In either circumstance, The ExerScience Center will never ask for credit card numbers via email or text message. If you think you may have received a suspicious email or text from The ExerScience Center, please contact our office immediately at 813.803-7070.

Email Appointment Confirmations
By opting in to email appointment confirmations, you will receive reminders of upcoming appointments, and reminders to schedule appointments.

Text Appointment Confirmations
By opting in to text appointment confirmations, you are authorizing The ExerScience Center to send text message appointment reminders to you on your provided cell phone number. You understand that you may reply with various commands to receive account information such as balances, future appointments, office location and other alerts as described in our Text Message System command list located on the text appointment confirmations page.

You also agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply.

Your enrollment indicates that your represent and warrant that you are the person legally responsible for all use of the accounts, are at least 18 years of age, and agree to all terms and conditions of use for the text messaging services.

The ExerScience Center offers a text messaging system to current patients to receive appointment confirmations, account balance information, and other services and content deemed appropriate. By opting-in to our text message system (via mobile opt-in or automated opt-in), you are providing consent to use personal information to provide the services available by The ExerScience Center, including customized content. Message and data rates may apply; please contact your wireless provider for specific information regarding your text messaging usage and charges.

The text messaging system is provided by The ExerScience Center to our patients on an as-is basis. Data obtained from you in connection with the text message system may include, but not be limited to, your name, address, cell phone number, office and location, future appointment dates and times, and account information. The ExerScience Center is not liable for any delays that may be experienced during the transmission of any messages, as delivery is based on the speed and effectiveness of your wireless provider.

Opt-Out Text Policy
You may opt-out of our text message system by replying with “STOP” or “UNSUBSCRIBE”. You will no longer receive appointment confirmations or other account information via text message if you opt-out of this service.

**The ExerScience Center Text Message System. Message and data rates may apply. By participating, you consent to receive text messages sent by an automatic telephone dialing system. Messages per month vary based on appointments scheduled. Consent to these terms is not a condition of purchase.*

For Help or Support: If you need assistance with your text message appointment confirmations or account alerts, please read the Frequently Asked Questions. If your question is not answered, you may contact us here, or simply reply with the word “**HELP**” to the message you received for assistance.

The ExerScience Center may terminate this agreement and any related services, with or without cause, at any time. All services are provided on an “as is” and “as available” basis without warranties of any kind, either express or implied, including, but not limited to, warranties of merchantability, fitness for a particular purpose or non-infringement. The ExerScience Center expressly disclaims any representation or warranty that the services will be error-free, timely, secure or uninterrupted. No oral advice or written information given by The ExerScience Center, its employees, licensors or agents will create a warranty, nor may you rely on any such information or advice. Under no circumstances will The ExerScience Center or its affiliates be liable for any direct, indirect, incidental, special or consequential damages that result from the use of or inability to use the services, including but not limited to reliance on any information obtained from the services, or that result from mistakes, omissions, interruptions, deletion of files, text, or e-mail; loss of or damage to data, errors, defects, viruses, delays in operation or transmission, or any failure of performance, whether or not limited to acts of god, communication failure, theft, destruction or unauthorized access to records, programs or services. The ExerScience Center reserves the right to modify the terms and conditions of use at any time and without advance notice, and any changes shall be effective upon making the modified provisions available on The ExerScience Center's website, and continued use of the services after any such changes shall constitute your consent to such changes. The ExerScience Center does not and will not assume any obligation to notify you of any changes to the terms and conditions of use. By signing up for this service, you agree that your sole and exclusive remedy to any issues arising from or relating to the services is to discontinue using the services. The terms of this section shall survive termination or revocation of the Patient Communication Consent Form and/or use of the services.

Supported Carriers: AT&T, Sprint, Nextel, Boost, Verizon Wireless, U.S. Cellular®, T-Mobile®, Cellular One Dobson, Cincinnati Bell, Alltel, Virgin Mobile USA, Cellular South, Unicel, Centennial and Ntelos

The ExerScience Center also provides automated opt-in to text message reminders when a valid cell phone number is provided during the patient registration and/or check-in process.

I consent to receiving electronic communications, including email and text messages regarding treatment, payment and health care operations in accordance with this document.

Signature: _____ **Date:** _____

The ExerScience Center

Cancellation/Missed Appointment Policy

In order to continue providing one-on-one care to our patients, The ExerScience Center requires a **24 hour notice within business hours** for all canceled and rescheduled appointments. Our goal is to give the best quality of service to our patients, and we would like to give patients on our waiting list the opportunity to be scheduled if you cannot keep your appointment. If you would like a reminder call for all your upcoming appointments, please let us know.

Please remember that you are reserving your time slot; no-shows and late cancellations without 24 hour notice will be charged the full cost of the scheduled appointment. Do not email schedule changes or cancellations. Please call 813.464.0313.

This will be your responsibility; insurance cannot be billed for this amount. This fee must be paid prior to being seen for your next appointment.

Thank you for your understanding with this matter.

Sincerely,
The ExerScience Center Team

I have read and understand the Cancellation Policy for The ExerScience Center.

_____ _____

Signature of Patient Date

The ExerScience Center

Financial Policy

Patient Name: _____ **Date:** _____

The ExerScience Center and affiliated companies, collectively known as "The ExerScience Center", are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "NEW CLIENT FORM" BEFORE STARTING SERVICE.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND ZELLE.**
- **THE EXERSCIENCE CENTER PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

Adult Patients

Adult patients are responsible for full payment at time of service.

Minors Accompanied By An Adult

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

Unaccompanied Minors

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

Insurance

The ExerScience Center provides insurance company billing as a courtesy to our patients. The patient portion of particular service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by The ExerScience Center staff regarding his/her remaining benefit in any such benefit period
The claims we submit to insurance companies indicate that you have assigned those benefits to The ExerScience Center. However, if you are paid by the insurance company instead of The ExerScience Center, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

Medicare/ Medicaid/ Champus/ Worker's Compensation

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the The ExerScience Center office on the date of service.

Delinquent Payments

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

Missed Appointments

No-shows and late cancellations without 24 hour notice will be charged the full cost of the scheduled appointment. Do not email schedule changes or cancellations. This will be your responsibility; insurance cannot be billed for this amount. This fee must be paid prior to being seen for your next appointment.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____ **Date:** _____

The ExerScience Center

MEDICAL and LIABILITY RELEASE

Name of Patient: _____DOB: _____
Please tell us of any condition that attending physicians should be aware of:

RELEASE FOR MEDICAL TREATMENT
It is necessary for you to authorize providers (including physicians, ambulances, etc.) to administer treatment in the case of emergency (accident, sudden illness, etc). Therefore, this release is **not complete nor will not be accepted by The ExerScience Center until this form is signed by the participant of legal age or the minor's parent or legal guardian.** This form has to be signed before the start of any training program.

RELEASE AND WAIVER OF LIABILITY
The undersigned hereby acknowledges that participation in any of The ExerScience Center's Physical Therapy and related activities involves an inherent risk of physical injury. Therefore, the Participant of legal age, parent or guardian hereby assume all such risk and do hereby release and forever discharge The ExerScience Center, its owners, officers, employees, and agents from any and all liability, regardless of the nature, arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, damages to property, and the consequences thereof, resulting from the Participant's active participation or involvement in any of The ExerScience Center, activity, or any failure of equipment or defect in the premises.

I have had a physical examination and been given permission by my physician to participate in The ExerScience Center's Physical Therapy, or I have decided to participate without the approval of my physician.

I/We hereby state that -- I am/we are – the parent(s)/legal guardians(s) of the applicant who is under legal age:

Participant Signature: _____

Parent Signature: _____

The ExerScience Center

Photo / Video Release Form

I hereby give The ExerScience Center permission to take photographs / videos of me or the minor named below or photographs / videos in which myself or the minor may be involved with others for the purpose of promoting The ExerScience Center. This hereby gives The ExerScience Center the absolute right and permission to use photographs / videos of myself or the minor in composite or retouched in character or form, in conjunction with advertising, or publishing.

I hereby release and discharge The ExerScience Center from any and all claims arising out of these photographs, or any rights that I or the minor may have.

I, _____ am of full age, and/or I am able to contract for the minor in the above regard. I have read the foregoing document and fully understand its contents.

Signature: _____

Print name: _____

Date: _____

I wish to **DECLINE** this service: _____

The ExerScience Center
24706 State Road 54
Lutz, Fl. 33559
Phone: (813) 803-7070
www.TheExerScienceCenter.com

Health Information Portability and Privacy Act

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. If you have any questions about this notice, please contact The ExerScience Center and/or personnel that provided your services. For your convenience, a listing of contacts is provided on the last page of this notice.

This Notice of Privacy Practice describes how The ExerScience Center may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. The ExerScience Center shall be referred to collectively as "The ExerScience Center" or "we" in this notice, and these referenced include all affiliates of The ExerScience Center which are identified on the last page of this Notice.

It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health records information that we maintain at that time.

Upon your request, we will provide you with any revised Notice of Privacy Practices. This notice became effective on April 14, 2003.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The ExerScience Center understands that medical information about you and your health is personal and confidential. We are committed to protecting medical information about you. We create a record of the care and services you receive at The ExerScience Center. This is needed to provide you with quality care and to comply with certain legal requirements, as well as billing purposes. This notice applies to all records of your protected health information generated by The ExerScience Center.

Notice Of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct certain mistakes on your medical record
- Request confidential communication
- Ask us to limit the information we share under certain circumstances
- Get a list of certain disclosures of your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/ hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/ noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Organizations
This Notice of Privacy applies to all affiliated entities doing business as The ExerScience Center.

Contact

The ExerScience Center
24706 State Road 54
Lutz, Fl 33559
Phone: 813.464.0313
Email: info@theexersciencecenter.com

Effective Date of this Notice: July 1, 2020

The ExerScience Center

HIPAA Privacy Practices Acknowledgment

Section A: Patient Information

Patient Name: _____

Patient Number: _____

Section B: Acknowledgment Of Receipt Of Hipaa Notice Of Privacy Practices

Notice of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Acknowledgment. We encourage you to read our Notice carefully and completely before signing this Acknowledgment.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain an additional copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

The ExerScience Center

Telephone: 813.803.7070

Email: info@theexersciencecenter.com

Section C: Signature

I, _____ have had full opportunity to read and consider the contents of this Acknowledgment and the Notice of Privacy Practices. I understand that, by signing this Acknowledgment, I am giving my authorization to your use and disclosure of my protected health information in accordance with the Notice.

Signature: _____ Date: _____

If this Acknowledgment is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Section D: For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other *(please specify):* _____

Signature: _____ Date: _____

You are entitled to a copy of this acknowledgment after you sign it.

The ExerScience Center

HIPAA Authorization

HIPAA Authorization for Uses and Disclosures of Protected Health Information

Authorization of Uses and Disclosures.
I hereby authorize and direct The ExerScience Center as well as their associated dentists, providers, employees, office staff, and agents including affiliated health care practitioners (collectively "The ExerScience Center") to use and disclose my "protected health information" ("Information"), as described below.

Description of Information.
I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information, including information about my health condition and related medical conditions, medical records, and financial information (including information about my insurance) as well as other personal information collected by The ExerScience Center about me or otherwise provided by me to The ExerScience Center.

Purposes.
I authorize and direct The ExerScience Center to use my Information, and to disclose my Information for the following purposes:

a. **For marketing communications.** For example – The ExerScience Center may contact me about new products, services, or events that it thinks may be of interest to me. The ExerScience Center may also contact me for the purposes of fundraising, publicity and advertising for broadcast in print or other media including on the internet. Note that The ExerScience Center may receive remuneration, either directly or indirectly, in exchange for making these marketing communications.

b. **For purposes related to treatment, payment (e.g., to a parent, other family member or personal representative who may assist in coordination of my care) and/or The ExerScience Center health care operations, with the following individuals:**

Name: _____

Relationship: _____

Telephone Number: _____

Treatment not Conditioned; Signing is Voluntary.
I understand that The ExerScience Center will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization and will still be able to receive treatment. In addition, if I refuse to sign this Authorization The ExerScience Center is still permitted to make uses and disclosures of my Information for treatment (e.g., to other health care providers), payment (e.g., to my insurance company), and health care operations (e.g., for internal audits), as permitted by law.

Expiration.
Unless revoked, this Authorization will expire ten (10) years from the date signed below.

Revocation.
I understand that I have the right to revoke this Authorization by providing written notice of my desire to revoke to **The ExerScience Center**, however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

Potential for Redisclosure.
I understand that Information disclosed pursuant to this Authorization may be redisclosed by The ExerScience Center and may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal privacy law.

Copy.
I understand that I will be provided with a copy of this signed Authorization.

I hereby certify that I am over the age of 18 and I have read the foregoing and fully understand the contents.

Name *(please print)*: _____

Patient Signature: _____ Date: _____

Date of Birth: _____ Age: _____

Parent/Guardian/Personal Representative Signature (required if subject is under 18 years of age)

Description of Relationship to Patient: _____

Health Information Portability and Privacy Act

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. If you have any questions about this notice, please contact The ExerScience Center and/or personnel that provided your services. For your convenience, a listing of contacts is provided on the last page of this notice.

This Notice of Privacy Practice describes how The ExerScience Center may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. The ExerScience Center shall be referred to collectively as "The ExerScience Center" or "we" in this notice, and these referenced include all affiliates of The ExerScience Center which are identified on the last page of this Notice.

It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health records information that we maintain at that time.

Upon your request, we will provide you with any revised Notice of Privacy Practices. This notice became effective on April 14, 2003.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The ExerScience Center understands that medical information about you and your health is personal and confidential. We are committed to protecting medical information about you. We create a record of the care and services you receive at The ExerScience Center. This is needed to provide you with quality care and to comply with certain legal requirements, as well as billing purposes. This notice applies to all records of your protected health information generated by The ExerScience Center.

The ExerScience Center

24706 State Road 54
Lutz, Fl 33559

Phone: (813) 803-7070

I have read and understand the Notice of Privacy practices of The ExerScience Center.

_____ _____

Signature of Patient **Date**

_____ _____

Please Print **Date**

I grant permission for The ExerScience Center to speak with the following individuals concerning myself and my treatment plan:

_____

_____

_____

_____

_____