

Your New Patient Paperwork needs to be completed prior to your first appointment. For your convenience, we've included the paperwork in this packet. You can save time by completing the paperwork ahead of time and bringing it with you 15 minutes prior to your scheduled appointment.

The following information must be reviewed, completed, and signed:

1. Patient Information
2. Informed Consent to Treatment
3. Current Problem & Medical History - 2 pages
4. Acknowledgement of Receipt of Privacy Practices
5. Treatment of Minor Consent (if patient is under the age of 18)

If you are unable to complete the paperwork ahead of time, please plan to arrive at least 30 minutes prior to your scheduled appointment to allow time for completion of the paperwork.

If you are under the age of 18, please have your parent or legal guardian complete the enclosed Treatment of Minor Consent form and bring it with you to your first visit.

We prefer to have your parent/guardian accompany you to your first visit.

If you need to cancel your appointment for any reason, please notify our office **at least 24 hours in advance** of your appointment by calling our scheduling office at **(800) 404-6050**. To assist you in keeping scheduled appointments, you will receive a courtesy reminder from our office.

WE LOOK FORWARD TO GETTING YOU PAIN FREE!





PATIENT INFORMATION

Patient's Name: _____ Gender: ____ D.O.B. ____ / ____ / _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Phone: (_____) _____ - _____

How did you hear about Airrosti? _____

Employer or School Name: _____

Emergency Contact: _____ Day Phone: (_____) _____ - _____

Financial Responsibility

In return for services rendered to me by the Airrosti Certified Provider, I promise to pay in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment for any reason.

ASSIGNMENT OF BENEFITS I understand that benefits quoted from my insurance carrier to Airrosti are only an estimate and not a guarantee of payment. I assign Airrosti all benefits payable to me under my insurance policies and health benefit plans. I shall be personally responsible for any unpaid balance to AIRROSTI Rehab Centers, LLC.

WORKERS' COMPENSATION Texas Department of Insurance – Division of Workers' Compensation (TDI-DWC) regulates fees and charges for medical aid, health care, and medicines. For those services provided which the TDI-DWC determines not to be work related, I understand that I am financially responsible. In the event of such determination, my insurance will be billed with benefits payable to AIRROSTI Rehab Centers, LLC.

MEDICARE I acknowledge that Airrosti is NOT a Medicare Provider and DOES NOT accept Medicare Benefits.

Release of Medical Information & Records

By signing below I authorize Airrosti Rehab Centers, LLC to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, communicating with my referring physician, and any administrative operations related to treatment or payment as noted in Airrosti's Notice of Privacy Practices. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I understand that Airrosti will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I retain the right to revoke this consent by notifying the practice in writing at any time. In addition, I am authorizing Airrosti to communicate my personal health information to the following individual(s), organization, or employer as I have written below:

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary.

Signature of Patient (If Minor, Signature of Legal Guardian)

Date

No Show/Cancellation Policy

Your Airrosti Treatment Team understands there may be circumstances which require you to cancel an appointment, but our requirement is that you notify our office at least 24 hours in advance. After one (1) "No Show" or two (2) "Less than 24 hours notice for cancellations", you will be limited to only Same Day Scheduling appointments. Same Day Scheduling means you can call in the morning to check for same day appointment availability.

To assist you in keeping your scheduled appointments, you will receive a reminder notification prior to your scheduled appointment.

Please acknowledge you have read and understand this policy by signing below.

Signature of Patient or Guardian

AIROSTI REHAB CENTERS, LLC

INFORMED CONSENT TO TREATMENT

Doctors of chiropractic and physical therapists who use manual therapy techniques such as the highly specific manual therapy, myofascial release, active rehab exercises, kinesio-taping, cryotherapy (ice), and occasional spinal adjustments should advise patients that there are or may be risks associated with such treatment. In particular you should note the following risks or complications:

- a) **Manual Therapy, Myofascial Release:** local discomfort, skin reddening, superficial tissue bruising, release of emboli (rare), post treatment soreness, or increase in pain which can last up to 72 hours or notice that symptoms shift to different areas which is rarely a concern
- b) **Active Rehab Exercises:** aggravation of present condition, blood pressure changes, increased heart rate
- c) **Kinesio-Taping and cryotherapy (ice):** skin reactions including, but not limited to itching, allergic reactions, hyperpigmentation (discoloration), and blistering
- d) **Sensitive Areas:** I recognize the nature of my injury may require the Airrosti provider(s) to perform treatment near or around sensitive area, i.e. chest, groin, buttocks, etc., and they will make every effort to safeguard my modesty and appropriately conceal the area
- e) There have been reported cases of injury to a vertebral artery following **cervical spine adjustments**. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in death. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, strokes (CVA), dislocations, and sprains. I do not expect my Airrosti Provider to be able to anticipate and explain all risks and complications. Further, I wish to rely on their professional and clinical judgment during the course of my treatment which the Airrosti Provider feels are in my best interests at the time, based upon the facts then known.

Knowing that I have a condition requiring health care, I voluntary consent to treatment performed by the Airrosti Certified Provider (including spinal manipulation). Though treatment is usually very beneficial and seldom causes any problems, I understand and have been informed of the potential risks. I have been informed about the methods used by Airrosti providers and have had the opportunity to ask questions and express concerns prior to treatment.

I have read and fully understand the above statements and I authorize Airrosti personnel to administer treatment as deemed necessary. I intend this consent to apply to all my present and future care.

Minor Consent: *If applicable, I have the legal right to select and authorize healthcare services for the minor child named above and I authorize an Airrosti provider to perform the treatment as outlined above to this minor.*

TO BE COMPLETED BY PATIENT:

Patient Signature: _____ **Patient Name:** _____
Signature of Patient/Legal Guardian (Please Print)

If Minor, Legal Guardian relationship to patient: _____

Date Signed: _____ **Patient Date of Birth:** _____

Witness Signature: _____ **Witness Name:** _____
(Please Print)

CURRENT PROBLEM & MEDICAL HISTORY

Patient's Name: _____ **Referring Doctor:** _____

Chief Complaint: Injury is on the: Right Side Left Side Both Sides

Please describe your injury and the purpose of your visit: _____

Mechanism of Onset:

How did your injury happen?

- Gradual/Over Time
- Traumatic/All of a Sudden
- Don't Know
- Chronic

How long ago did it happen?

- Less than 14 days
- 2 weeks to 12 weeks
- 12 weeks to 1 year
- More than 1 year

For Work-Related Injuries:

Specific Injury Date: ____/____/____

Work Status: _____

Pain: Please rate your pain (0=no pain - 10=worst pain ever). Circle one: 0 1 2 3 4 5 6 7 8 9 10

How much pain are you in today? None Very Little Moderate Significant Extreme Pain

When does your injury cause you pain?

- Constantly
- On and Off

What time of day does your injury cause you pain?

- Morning
- Afternoon
- Night

What best describes your pain?

- Ache
- Burning
- Dull
- Numbness
- Radiating
- Sharp
- Shooting
- Stabbing
- Throbbing
- Tingling

What best relieves your pain?

- Medication
- Heat
- Cold/Ice
- Rest
- Activity
- Nothing

What makes your pain worse?

- Standing
- Sitting
- Rest
- Activity
- Other _____

Sleep Disturbances: Difficulty Falling Asleep Difficulty Finding Comfortable Position Awakened by Pain

Prior Treatment for This Injury:

- Have You Had Surgery for This Injury? Yes No
- Have You Seen a Specialist For This Injury? Yes No
- Were You Hospitalized For This Injury? Yes No
- Were You Advised to Have Surgery For This Injury? Yes No
- Any P.T. or Chiropractic Care For This Injury? Yes No

Comments:

 _____ # of Visits

Medications: Are you taking any Medication for THIS Injury? Yes No

Please list all other Medications that you are taking below:

- Pain
- Steroids
- Diabetic
- Antidepressant
- Allergy
- Muscle Relaxers
- Blood Thinners
- Cholesterol
- Anti-inflammatory
- Cardiac
- Hypertension
- GI Tract

Please comment on any other medications not listed:

Diagnostic Tests: Did you have any Diagnostic Imaging performed for THIS Injury? Yes No

- MRI
- Bone Scan
- EMG
- EEG
- CT Scan
- X-Ray
- Nerve Conduction
- Bone Density Scan

Please comment on any **positive** diagnostic test(s):

Medical Conditions: Please indicate any of the following medical conditions you have experienced with THIS injury.

- Fracture
- Muscle Tear
- Tendon/Ligament Tear
- Obstructive Edema
- High Blood Pressure
- Osteoporosis
- Warm Inflamed Skin
- Active Hemorrhage
- Localized Infection

CURRENT PROBLEM & MEDICAL HISTORY (cont.)
PERTINENT MEDICAL HISTORY

Medical Condition

- | | | | |
|----------------------------------------------|-----------------------------------------------|------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bone or Joint Disease | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Colon Infection |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Recurrent Headaches | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Seriously Depressed | |

Allergies

- Seasonal _____
- Food _____
- Latex _____
- Other _____

Lifestyle Activities

Hobbies: _____

Sports: _____

Other Physical Activities: _____

FOR WOMEN ONLY

Please fill in the number of: _____ Pregnancies _____ Births _____ Children

Please give any additional information on any difficult pregnancies, delivery complications, and/or menstrual problems:

Prior to Treatment

Is there anything else your provider should know about your condition prior to treatment? _____

PATIENT SIGNATURE

Signature of Patient (If Minor, Signature of Legal Guardian)

Date

Do not write below. For Airrosti Provider use only:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of AIRROSTI REHAB CENTERS, LLC describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Date

Signature of Patient (If Minor, Signature of Legal Guardian)

Printed Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____(patient's name) receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- Patient Unavailable
- Patient Physically Unable
- Patient Unwilling

In an effort to obtain the patient's acknowledgement, The Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- Personally Mail Phone Follow Up
- Other _____

Date

Signature

Printed Name of Physician

AIRROSTI REHAB CENTERS, LLC

Name of Practice

AIROSTI REHAB CENTERS, LLC

NOTICE OF PRIVACY PRACTICES

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

Our practice is dedicated and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of January 1, 2004 and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. CONSENT: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connections with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

Our chiropractic practice will seek to obtain Consent from you permitting us to use or disclose your health information for these activities. You should be aware that our chiropractic practice does not require obtaining or confirming the existence of Consent, prior to:

- a) Emergency treatment;
- b) Treatment, when such treatment is required by law; or
- c) Treatment of patients when communication barriers prevent obtaining Consent.

You should also be aware that you have the right to revoke that Consent at any time by providing the practice with written notice.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patients Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

- A. **ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you a reasonable fee for the labor of copying your records (not including record handling and record retrieval), a \$1.00 per pages 11-60, \$.50 per page for pages 61-400, and \$.25 per page for pages over 400, and postage if you want the copies mailed to you. A reasonable fee for copies of films may also be charged, but not to exceed \$45 for retrieval and processing, including copies for the first 10 pages, and \$1.00 for each additional page. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.
- B. **ACCOUNTING OF CERTAIN DISCLOSURES:** Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- C. **RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS:** You have the right to request that we place additional restrictions on our use of disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or locations you request.
- D. **AMENDMENTS TO RECORDS:** You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.
- E. **ELECTRONIC NOTICES:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Kim Fairchild
Telephone: 800-404-6050
Fax: 866-298-4032

Address: AIRROSTI REHAB CENTERS, LLC
911 Central Parkway North, Suite 300
San Antonio, TX 78232