TRAIN BOSTON SPORTS CENTER, LLC
TRAIN BOSTON PHYSICAL THERAPY, INC.
WAIVER

Name_____ Date_____

Address_____ City, State, Zip_____

Home Phone_____ Cell Phone_____ Date of Birth_____

E-Mail Address_____ Gender: Male _____ Female _____

Emergency Contact Name_____ Phone_____

How did you hear about us?

_____

I authorize Train Boston to use my photograph/video on multi-media platforms.

I understand and agree that TRAIN BOSTON is not responsible for property that is lost, stolen, or damaged while in, on, or about the premises regarding the use of the facilities and equipment.

_____

Authorized Signature

If on behalf of a minor child

Name of Child: _____

Relationship to child: _____

SEE OTHER SIDE

Office Use:

_____ _____ _____

Entered Arrivals Staff Initial

Client Type: (Circle One) Child Teen Adult Senior Physical Therapy

TRAIN BOSTON SPORTS CENTER LLC
TRAIN BOSTON PHYSICAL THERAPY, INC.
WAIVER

I understand and am aware that strength, flexibility, and aerobic exercise, including outdoor activity and the use of the exercise equipment and facilities and training provided by Train Boston Sports Center, LLC or by Train Boston Physical Therapy, Inc. (collectively TRAIN BOSTON) is potentially hazardous to my health. I also understand that fitness activities involve a risk of injury and even death, and that I am participating in these activities and using the equipment, machinery and training with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risk of injury or death. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, or illness that would prevent my participation or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation and activities, and utilization of equipment and machinery in my activities. I also acknowledge that my Personal Trainer, Physical Therapist or Instructor has advised me regarding the proper use of the equipment and machinery and the risks such use might entail, including the risk of personal injury. I acknowledge and agree that I will only make use of the equipment and machinery strictly in accordance with the instructions of my Personal Trainer, Physical Therapist or Instructor. In consideration of my use of the exercise equipment and facilities I expressly agree and contract, on behalf of myself, my heirs, executors, administrators, successors and assigns, that the company and its insurers, employees, managers, members, officers, directors, and associates, shall not be liable for any damages arising from personal injuries (including death) sustained by me, or my guest in, on, or about the premises, or as a result of the use of the equipment or facilities, regardless of whether such injuries result, in whole or in part, from the negligence of TRAIN BOSTON, its agents or employees and By the execution of this agreement, I accept and assume full responsibility for any and all injuries, damages (both economic and non-economic), and losses of any type, which may occur to me or my guest, and I hereby fully and forever release and discharge the company, its insurers, employees, officers, directors, and associates, from any and all claims, demands, damages, rights of action, or causes of action, present or future, whether the same be known or unknown, anticipated, or unanticipated, resulting from or arising out the use of said equipment and facilities. I expressly agree to indemnify and hold TRAIN BOSTON harmless against any and all claims, demands, damages, rights of action, or causes of action, of any person or entity, that may arise from injuries or damages sustained by me or my guest. I agree to be solely responsible for safety and well being of my guest and myself. I agree to comply with all rules imposed by TRAIN BOSTON. I agree to conduct myself in a controlled and reasonable manner at all times, and to refrain from using any equipment in a manner inconsistent with its intended design and purpose.

If any portion of this waiver shall be deemed by a Court of competent jurisdiction to be invalid, then the remainder of this waiver shall remain in full force and effect and the offending provision or provisions severed here from.

I HAVE READ THE FOREGOING WAIVER AND VOLUNTARILY EXECUTED THIS DOCUMENT WITH FULL KNOWLEDGE OF ITS CONTENT

Signature_____ Date_____

Print Name:

If on behalf of a Minor Child Print name of child and relationship to child: _____

Train Boston Physical Therapy

These forms must be filled out by a parent/guardian for any patient under the age of 18.

*HAVE YOU HAD PHYSICAL THERAPY AT ANOTHER FACILITY DURING YOUR INSURANCE POLICY PLAN YEAR? **YES** **or** **NO** (Circle One). If YES, how many visits?_____

Name: Date:

Street Address: DOB:

City:_____ State:_____ Zip:_____ Email:_____

Home Ph#_____ Work Ph#_____ Cell #:_____ Sex: M F

EMERGENCY CONTACT NAME:_____ Phone:_____

REFERRING MD:_____

PRIMARY CARE
PHYSCIAN:_____

I authorize Train Boston Physical Therapy Inc. to communicate with me via email. I consent in writing to receiving email reminders and understand that such emails may contain health information.

Authorized Signature: _____

Physical Therapist's Initials:_____

Train Boston Physical Therapy

Patients Name:_____

MEDICAL & SOCIAL HISTORY INFORMATION

Please provide our physical therapists with as much family history and personal information as possible. There is a space provided at the bottom of this form for any additional information that you feel may be pertinent to your case. Best estimates are fine if you cannot remember specific details. If you are uncomfortable with any question, do not answer it.

Please check all that apply:	N/A	YOU	FAMILY
Hypertension (High blood pressure):			
Osteoporosis:			
Myocardial Infarction (heart attack):			
Gastric-Intestinal problems:			
Congenital Heat Disease, specify type:			
Lung/respiratory conditions:			
Asthma:			
Diabetes, specify type:			
Pregnant:			
Pacemaker:			
HIV / AIDS:			
Cancer, specify type:			
Prior fractures, specify:			
Arthritis, specify type:			
Prior neck and/or Back condition:			
Allergies, specify type and reaction:			
Prior ligament sprain/strain, specify:			
Lupus:			

Do you exercise regularly? No_____ Yes_____

At this time are you taking any medication? Y or N. If yes, please list below.

_____ _____ _____

_____ _____ _____

Any physician restriction concerning exercise? Y or N. Explain below:

Currently, is there any other medical ailments or conditions requiring treatment besides your injury/accident that you are here? Y or N? Explain below:

Please list below any conditions that may have required surgery in the past and the surgery date:

Please list below any other medical information you would like us to know:

_____

Therapist's Initials

Patients Name: Train Boston Physical Therapy

CURRENT CONDITION INFORMATION

Briefly describe the current condition in which you are seeking care: _____

_____

_____

Most recent doctor visit?_____ Next Doctor visit? _____

Have you had any previous treatment for this condition? Y or N? (check all that apply.)

☐**Physical therapy** ☐**Occupational therapy** ☐**Home Care Services (VNA)**

☐**Surgery** ☐**Massage** ☐**Bracing** ☐**Acupuncture** ☐**Chiropractor**

How would you describe any pain you are experiencing? (check all that apply.)

☐**Numb** ☐**Tingling** ☐**Dull** ☐**Deep** ☐**Superficial** ☐**Constant** ☐**Intermittent** ☐**Occasional**

☐**Cramping** ☐**Nagging** ☐**Intolerable** ☐**Diffuse** ☐**Sharp** ☐**Burning** ☐**Aching**

What are your goals for Physical Therapy?

What activities are you having difficulty with? (example: driving, walking, sitting, lifting, working)

What makes the injury Worse?

What makes the injury better?

Please check the following boxes if you are experiencing any of the following:

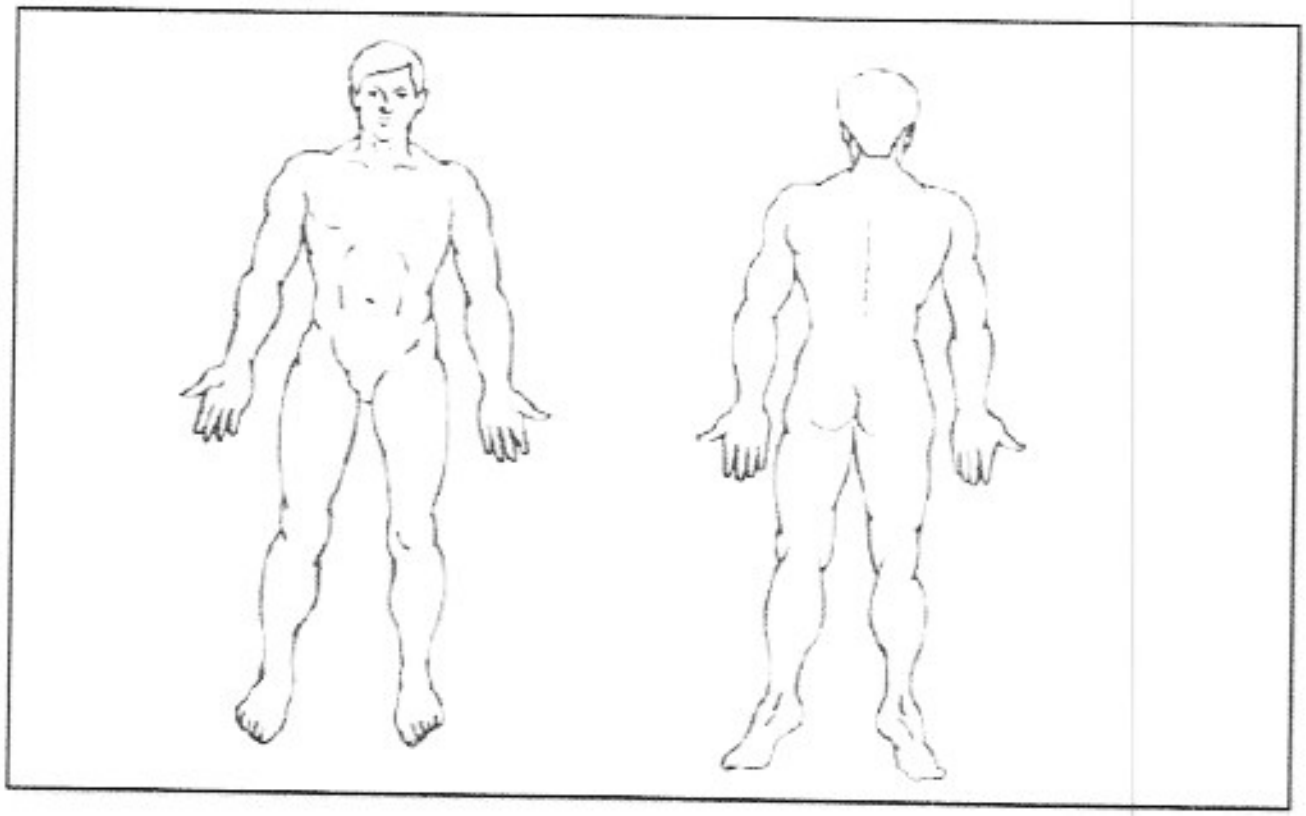
☐Unexplained weight loss	☐Persistent pain at night	☐Shortness of breath
☐Unusual lumps/growths	☐Unwarranted fatigue	☐Pulsating pain
☐Dizziness	☐Pain or heaviness in chest	☐Bladder/bowel changes
☐Constant/Severe pain in the calf	☐Swelling with unknown cause	☐Changes in hearing
☐Frequent heart burn	☐Frequent nausea or vomiting	☐Balance or coordination problems
☐Menstrual cycle irregularities	☐Fever or night sweats	☐Sudden weakness
☐Recent severe emotional disturbance	☐Pregnancy	
☐Swelling/redness without cause	☐Changes in vision	
☐Severe headaches without cause	☐Fainting spells	
☐Recent fall	☐Abdominal pain	

Have you had diagnostic imaging for this condition? (ie, X-Ray, MRI, etc...) If yes, please describe any known results.

_____
Therapist's Initials

Patients Name:_____

Please mark on the diagram below where you experience any symptoms related to your injury:



Using a 0-10 scale to rate your pain, with zero equaling no pain and ten equal to the most pain imaginable, answer the following questions.

In the past 48 hours, how would you rate your pain at worst? _____/10

In the past 48 hours, how would you rate your pain at best? _____/10

_____

Therapist's Initials

Train Boston Physical Therapy, Inc.

TRAIN BOSTON

Physical Therapy

Account Balance Automated Billing Authorization

In some cased, according to your insurance company contracts, a portion of the fee due from must be paid by you the day the service is provided and Train Boston Physical Therapy, Inc. is obligated to wait for the insurance company to pay its portion of the services provided. . There are times that after we receive the insurance company payment that there will be a balance remaining from you due to reasons such as; co-pays, co-insurances, deductibles, and benefit maximums, etc.

In the event the Insurance Company fails to pay the anticipated amount, you will be responsible for the balance due. We require that arrangements be made in advance to cover these balances by the use of a credit card that you leave on file with us. In the event we need to charge your credit card, we will email a statement and receipt to you.

The undersigned hereby authorizes Train Boston Physical Therapy, Inc. ("TBPT") to retain my credit card information on file as part of my physical therapy record, for payment purposes only. This authorization relates to any co-pay and to all payments not covered by my insurance company for services provided to me by Train Boston Physical Therapy, Inc. . I hereby give my consent to TBPT to charge any outstanding balance to my credit card on file. This balance may include co-payments, co-insurances, deductibles, denials, and non-covered services.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give notification to TBPT in writing and the cancellation will not affect payment for prior services rendered..

Please see one of our front desk coordinators and they will input your credit card information into the system on the date of your first visit. Please note this information is kept in an encrypted file.

Authorized Signature _____

Print Name _____ Date: _____

It is the patient's responsibility to understand their physical therapy insurance coverage. If you have any questions about your health insurance coverage, please contact Member Services at the number on your insurance card.

Patient's Initials _____

Therapist's Initials

Train Boston Physical Therapy
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" (PHI) by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information" (PHI).

Permitted Uses and Disclosures of PHI

Train Boston Physical Therapy uses your PHI for the following:

- Treatment: provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.
- Payment: activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual.
- Health care operations: are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs

Your Health Information Rights

Although your health record is the physical property of Train Boston Physical Therapy, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record
- Request to amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

I acknowledge receipt of a copy of this Notice:

Signature: _____ Date: _____

Train Boston Physical Therapy

Insurance Authorization and Assignment of Insurance Benefits

I authorize and assign TRAIN BOSTON PHYSICAL THERAPY all payments rendered to myself or my dependent AND I understand that I am fully responsible for any balance that is not covered by my insurance company.

Signature: _____ Date: _____

Cancellation and No-Show Policy

It is the policy of Train Boston Physical Therapy that any patient who is unable to provide a 24-hour notice of cancellation or who does not show up for their appointment will be charged a **fee equal to the amount of the cost of your session**, not to exceed $80. The fee must be paid at your next visit and cannot be billed to your insurance company.

Signature: _____ Date: _____

Physical Therapy for a Minor (patient under age 18)

I give Train Boston Physical Therapy permission to evaluate and treat my child.

Name of Parent/Guardian: _____

Address: _____

Telephone: _____ Relationship to patient: _____

Signature: _____ Date: _____