Client Information

Patient Information

Name: ____________________
Last First Middle

Date of birth: ____________ Social Security #: ____________

Address: ____________________
and Street City State Zip Code

Home phone: ____________ Work phone: ____________

Cell phone: ____________ Email address: ____________

Health Insurance

Carrier Name: ____________________

Address: ____________________
and Street City State Zip Code

Group Number: ____________ Subscriber Number: ____________

Insurance Type: ____________

Please attach a copy (front & back) of your insurance card.

Doctor Information

Name: ____________________

Address: ____________________
and Street City State Zip Code

Phone #: ____________ Email address: ____________

Injury Information

Injury Level ____________ Date of Injury: ____________

Auto Accident: Yes No

Work Related: Yes No

Other: ____________

Current Medications:

Medication Allergies:

Current Conditions:

Previous Illnesses:

Short-term goals

Long-term goals

Whom may we contact in case of emergency?

Name: ____________ Phone: ____________

Relationship: ____________

*IF PATIENT IS A MINOR, WHO IS AUTHORIZING TREATMENT?

Name: ____________________
Last First Middle

Address: ____________________
and Street City State Zip Code

I certify this information is true and correct to the best of my knowledge, and I will notify you of any changes.

Signature: ____________ Date: ____________

Patient (minor): ____________ Date: ____________

WAIVER AND RELEASE FROM LIABILITY FOR USE OF NEXTSTEPS

I, ______________________________, HEREBY WAIVE AND RELEASE, indemnify, hold harmless and forever discharge NextSteps and its agents, employees, officers, directors, affiliates, successors and assigns, of and from any and all claims, demands, debts, contracts, expenses, causes of action, lawsuits, damages and liabilities of every kind and nature, whether known or unknown, in law or equity, that I ever had or may have, arising from or in any way related to my participation in any of the events or activities conducted by or on the premises of or for the benefit of NextSteps.

Client acknowledges that any activities client participates in can be an extreme test of client physical and mental limits and carry the potential for severe physical injury. Client hereby assumes the risks of participating in any and all of Next Steps activities and functions. Client certifies that client is able to participate in the NextSteps program and has not been advised otherwise by a qualified medical person. Client understands that the information and treatments obtained by participating in NextSteps do not constitute medical treatment, diagnosis or advice. Client understands that client should seek the advice of a physician or other qualified health provider if client has questions about a medical condition. Client understands that a bone density scan is required to enter NextSteps and client agrees and acknowledges that Client will have taken such bone density test and shared the results of such test with NextSteps before beginning any treatments with NextSteps. Client certifies that in consideration of becoming a client of the program, Client hereby takes the following action for itself, its executors, administrators, heirs, next of kin, successors and assigns:

Client waives, releases and discharges from any and all claims or liability for any loss, damage, theft or injury of any kind which arise out of or related to its participation in, or its traveling to and from the NextSteps center; including but not limited to, I} any known and unknown, foreseen and unforeseen bodily and personal injury, 2} loss of life, and 3} any attorney's fees, costs, expenses, or charges sustained, directly or indirectly, or alleged to have been sustained, or in any fashion, arising from, in connection with, or resulting from its participation in NextSteps.

Client agrees to the utilization of any video(s)/photo(s) taken at NextSteps to be utilized for education and advertising purposes.

____

Date

____

Printed Name

____

Signature

HIPAA Notice of Privacy Practices

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. 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 health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to receive an accounting of certain disclosures we have made, of any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will NOT retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **May 7, 2007**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions concerning or objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at ~~[illegible]~~. 708.467.0657

Your signature below acknowledges that you have received a copy of this Notice of our Privacy Practices.

Print Name: ______________________________ Date: ____________________

Signature: ______________________________