

Reactive, LLC
PATIENT INFORMATION FORM

Today's Date: _____

Patient Name: _____ DOB: _____ Age: _____

Home number: _____ Cell number: _____

Email address (used *only* for Reactive PT communication): _____

Reason for coming to PT: _____

Goals you would like to achieve as a result of your PT:

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Primary Care Physician: _____

Emergency Contact (name and phone number): _____

Past Surgeries: _____

Current Medications: _____

Allergies: _____

Circle any conditions you have or have had in the past:

Cancer	Unexplained weight loss	Kidney problems
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High blood pressure	Infectious disease	Diabetes
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Osteoporosis	Thyroid Problems	Broken bones
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Asthma	Bowel/bladder problems	Stroke
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Dizziness	Heart problems	Arthritis
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Pacemaker	Fever/Chills	Head Injury
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Other: _____

Pain of current symptoms (0 = none, 10 = severe) _____

Cancellation Policy

In the event you need to cancel an appointment, you must provide 24 hour advance notice. In the event you miss an appointment without canceling, a \$45 fee may be assessed. If you arrive late for an appointment, payment in full is still required for the allotted treatment time.

Reactive, LLC
CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR TREATMENT

I hereby consent to receive physical therapy services (including, without limitation, examination, diagnosis and treatment) to be performed by Reactive, LLC (“Reactive”).

RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

I hereby permit Reactive to furnish my medical information to my named physician(s) and emergency contact. I agree that I am responsible for all payments due for services rendered on the date that such services are rendered. I agree that if I arrive late for an appointment, payment in full is still required for the allotted treatment time. If I need to cancel an appointment, I agree that I must provide 24 hour advance notice. I agree that a \$45 fee may be assessed in the event that I miss an appointment without calling to cancel.

I agree that it is my responsibility to immediately notify Reactive in writing in the event of any changes to the information provided to Reactive, including without limitation my physician(s) or emergency contact.

I have received a copy of Reactive’s Notice of Privacy Practices.

I have read the above, and I understand and agree to these terms.

Signature of patient (or parent or guardian if under 18)

Print Name: _____

Date: _____

Reactive, LLC
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.

This Notice will tell you about the ways in which Reactive, LLC (“Reactive” or “we”) may use and disclose medical information about you. It also describes your rights and certain obligations that we have regarding the use and disclosure of your medical information.

Reactive is covered by regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and is required by law to maintain the privacy of your health information, give you notice of our privacy practices with respect to your medical information, and follow the terms of this Notice. This Notice applies to all of the records of your care generated and maintained by Reactive.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose your medical information. These are examples and, therefore, not every permitted use and disclosure is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may also disclose medical information about you to your physicians, family members, or other health care related entities such as skilled nursing care facilities with whom you seek treatment.

Appointment Reminders. We may use and disclose your medical information to contact you as a reminder that you have an upcoming appointment for treatment.

Treatment Alternatives. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose your medical information to tell you about health-related benefits or services that may be of interest to you.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Lawsuits and Disputes. We may disclose medical information about you in response to a Court Order, Administrative Order or certain subpoenas.

Law Enforcement. We may release medical information to a law enforcement official in emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence and other national security activities authorized by law.

OTHER USES OF YOUR MEDICAL INFORMATION

Other uses and disclosures of your medical information not covered by this Notice or required by the laws that apply to Reactive, will be made only with your written permission (your written permission is referred to as an “Authorization”). If you provide your permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons indicated in your written Authorization. You understand that we are unable to take back any disclosures that we made before we received your written notice revoking your Authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your medical information. This includes your medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. To inspect or obtain a copy of your medical information, you must submit your request in writing to Reactive.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long the information is kept by Reactive. To request an amendment to your medical information, you must submit your request in writing to Reactive. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by us;
- Is not part of the information which you would be permitted to inspect and copy;
or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures”. This is a list of the disclosures we made of your medical information. This

list will not include disclosures that we made for purposes of treatment, payment and health care operations. We are also not required to include in this list the disclosures we made by acting upon your written authorizations.

To request an accounting of disclosures, you must submit your request in writing to Reactive at the following address: 9863 Montgomery Road, Cincinnati, Ohio 45242.

Your request must state a time period which may not be longer than six (6) years. The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request for a restriction or limitation. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have a right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. You may also obtain a copy of this Notice at our website, www.goReactive.com.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Reactive or with the Secretary of the U.S. Department of Health and Human Services.