AIS THERAPY

John Howard, LMT

PATIENT INFORMATION

PATIENT

Last Name:_____ First Name:_____ MI:_____

___ M___F Date of Birth: _____/_____/_____ Age: _____

Home Address:_____ Apt# _____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____

Marital Status: ___ Single ___ Married ___ Divorced ___Widowed

Employment Status: ___ FT ___PT _Unemployed ___Retired ___ Student

Employer:_____ Work #:_____ Occupation:_____

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

SPOUSE or GUARDIAN

Last Name :_____ First Name:_____

Employer:_____ Work#_____

EMERGENCY

Last Name :_____ First Name:_____

Relationship:_____ Home #:_____ Cell #:_____

Work#_____

How did you hear about our clinic ?_____

Referring Physician :_____ ***Phone#***_____

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

NAME OF RESPONSIBLE PARTY OR GUARANTOR

Last Name:_____ First Name:_____

Home Address:_____ Apt#_____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____

John Howard, AIS THERAPY

Patient History Information

Last Name:_____ First Name:_____ MI_____

_____Male _____Female Age:_____

Please CIRCLE NO or YES for those conditions that apply to you:

History of high or low blood pressure?	Y or N	Previous neck or back problems?	Y or N
History of heart or blood vessel disease?	Y or N	Currently have visual/hearing problems?	Y or N
Previous heart attacks?	Y or N	Any sensory disturbances?	Y or N
Previous strokes - CV A?	Y or N	History of cancer? When?	Y or N
Currently have a pacemaker?	Y or N	Any unusual reactions to heat or cold?	Y or N
Diabetes?	Y or N	Any broken bones?	Y or N
Arthritis or any other joint problems?	Y or N	Any allergies? Please list	Y or N
Presently have any metal implants?	Y or N	OTHER:_____	

If you have answered **YES** to any of the above questions, please describe further:

List all current medications:

List previous hospitalizations/surgeries (especially those within the last 6 months) and all diagnosis:

Describe your chief complaint or problem requiring therapy services:

Describe any prior therapy related to this condition (when, how long and the outcome):

What was your prior activity level, including recreational activities?

Please **CHECK** if you have started to have difficulty with any of the following functional abilities:

_Eating
_Dressing
_Grooming
_Bathing
_Toileting

_Walking with/without assistive device
_Balance
_Mobility
_Getting from bed to chair
_Standing up from bed or chair

_Swallowing foods
_Swallowing liquid
_Speaking clearly
_Expressing needs/wants

This form was completed by the:

Patient___ Patient Representative___ Patient with help from therapist___

John R. Howard, LMT, CES, NMT

AIS THERAPY
425 E. Crossville Road, Bldg E, Suite #117
Roswell, GA 30075 Phone: (770) 815-3365 Fax: (770) 674-1911
Email: john@aistherapy.com Website: www.aistherapy.com

Please Note: John Howard charges $100.00 each hour for his rendered services.
He accepts Cash, Personal Checks & Major Credit Cards

Patient Name:_____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA)

I acknowledge that I have received the attached Privacy Notice

Patient or Personal Representative Signature:_____ Date:_____

Printed Name:_____

If Personal Representative's signature appears above, please describe Personal

Representative's relationship to the patient: _____

Please answer the following questions to help us protect your privacy:

1) May we leave a detailed message on your answering machine? YES/NO Ph#_____
2) May we leave a message at your place of employment? YES/NO Ph#_____
3) If the answer to the above questions is NO, please let us know how you wish to be notified by our office:
4) May we release information to anyone other than you? YES/NO

If the answer is **YES**, please list each person *(Example: spouse, child, friend, etc.*:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE

COVID-19 Liability Waiver

First Name _____ Last Name _____

Date of Birth _____ Date _____

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
I further acknowledge that AIS THERAPY LLC has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
I further acknowledge that AIS THERAPY LLC can not guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, clinic staff, and other clinic clients and their families.
I voluntarily seek services provided by AIS THERAPY LLC and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.
I attest that:
* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* I have not traveled internationally within the last 14 days.
* I have not traveled to a highly impacted area within the United States of America in the last 14 days.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non contagious by state or local public health authorities.
* I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.
I hereby release and agree to hold AIS THERAPY LLC harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the clinic, or that may otherwise arise in any way in connection with any services received from AIS THERAPY LLC. I understand that this release discharges AIS THERAPY LLC from any liability or claim that I, my heirs, or any personal representatives may have against the clinic with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from AIS THERAPY LLC. This liability waiver and release extends to the clinic together with all owners and employees.

_____
Signature

Effective date of notice: February 27, 2006

NOTICE OF PRIVACY PRACTICES

John Howard, AIS THERAPY
425 E. Crossville Road, Bldg E , Suite #117
Roswell, GA 30075 (770) 815-3365

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operation. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, conducting an evaluation to determine treatment and coordinating a treatment plan with your physician. Examples of you we use or disclose your health information for payment purposes are: asking you about your health or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health Care Operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose you health information for health care operations are: financial or billing audits; internal quality assurance; personal decisions; participation in managed care plans; defense of legal matters; and business planning.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside our office for these reasons, we usually will not ask you for special permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some situations, the law allows or requires us to disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation, or surveillance; and notices to and from federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to government authorities about victims or suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as in response to subpoenas or orders of courts or administrative agencies;

- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses and disclosures to prevent a serious threat to health or safety;
- Disclosures relating to worker's compensation programs;
- Disclosures to "business associated: who perform health care operations for us and who commit to respect the privacy of your health information'

Unless you object, we will also share relevant information about you care with family or caregivers who are helping you with your treatment.

APPOINTMENT REMINDERS

We may call to remind you of scheduled appointments, or to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may leave your message on your home answering machine or with someone who answers your phone if you are not at home.

OTHER USES AND DISCLOSURES

We will not make any other uses of disclosures of your health information unless you sign a written "authorization form." Federal law determines the content of an "authorization form". Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use a disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment, payment or health care operation. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address at the beginning of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, or by mailing health information to a different address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask us for confidential communication, send a written request to the office contact person at the address shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. You will have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can only have one 30 day extension of the time for us to give you access of photocopies if we send you a

written notice of extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address shown at the beginning of this notice.

- Ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address shown at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice and have copies available in our office.

COMPLAINTS

If you think we have not properly respected the privacy of your health information, you are free to complain to U.S. Department of Health and Human Services or the Office, us for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the above address or phone number shown at the beginning of this notice.