INFORMED CONSENT AGREEMENT

Thank you for choosing to use the facilities, services, or programs of Life Elevated Therapy. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

I, the undersigned, declare that I intend to use some or all of the activities, facilities, programs, and services offered by Life Elevated Therapy and I understand that each person, (myself included), has a different capacity for participation in such activities, facilities, programs, and services. I am aware that all activities, services, and programs offered are educational, recreational, or self-directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or heath (physical, mental, or emotional) and to the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, services, and program of Life Elevated Therapy brings with it my assumption of those risks or results stemming from this choice and the fitness, health, and awareness, care, and skill that I possess and use.

I further understand that personnel, who may not be licensed, certified, or registered instructors or professionals sometimes conduct the activities, programs, and services offered by Life Elevated Therapy. I accept the fact that the skills and competencies of some employees and/or volunteers will vary according to their training and experience and that no claim is made to offer assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certified, or registered, and herein employed to provide such professional services. I recognize that by participating in the activities, facilities, programs, and services offered by Life Elevated Therapy, that I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, and nausea, and that I assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity or procedure if I so desire and that I may also be requested to stop and rest by a supervising employee who observes any symptoms of distress or abnormal response.

I understand that I may ask any questions or request further explanation or information about the activities, facilities, programs, and services offered by Life Elevated Therapy at any time before, during, or after my participation. I declare that I have read, understood and agree to the contents of this informed consent agreement in its entirety.

x____/______/______

Patient/Responsible Party Relationship to patient Date

PHOTO AND VIDEO AUTHORIZATION

At times we take photos or video to monitor and record your progress. At other times we may use video for teaching or marketing purposes. I hereby consent without further consideration or compensation, to give Life Elevated Therapy, the absolute right and permission to use my photograph or video in its promotional materials, publicity efforts, advertisements and social media. I hereby grant permission to Life Elevated Therapy to crop, screen, or alter the photograph or video as necessary for use on materials produced by and on behalf of Life Elevated Therapy. I understand that these images may be used alone or in conjunction with other photographs or videos for educational purposes, still or moving, sketches, advertising and publication in any manner and in any medium whatsoever without limitation or reservation. *I release all claims against Life Elevated Therapy, their employees, agents and designees from liability for any violation of any personal or proprietary right I may have in connection with such use.*

x____/______/______

Patient/Responsible Party Relationship to patient Date

Cancellation/ No Show Policy

Your progress and recovery are dependent on both our expertise and your active participation and commitment to your appointments. Please call **48 hours** prior to your appointment if you need to cancel or reschedule.

A **$25 fee** per 60 minute session will be due on your next scheduled date of service if you no show or cancel 48 hours or less before your appointment.

Three (*3) cancellations or no shows without 48 hour notice in a 3 month period will result in automatic cancellation of all your future appointments. You may go back onto our waiting list once you are fully committed to return to your scheduled therapies.*

x____/______/______

Patient/Responsible Party Relationship to patient Date

x____/______/______

Life Elevated Therapy Employee Witness Date

FINANCIAL POLICIES AND PROCEDURES

Patient Name____ **Date of Birth**_________________ **Today's Date**____________

I authorize payment of my insurance benefits directly to Life Elevated Therapy and authorize Life Elevated Therapy to disclose my protected health information to assist with the processing of my claim(s); carry out my treatment; and for health care operations like quality reviews. I understand I am personally responsible for balances not paid by my insurance. I understand I will be notified by invoice of the amount charged to either my insurance/bank account/or credit card. Claims are submitted by Life Elevated Therapy within two business days of the date of service.

BILLING PROCEDURE: If your insurance is out of network, you will pay Life Elevated Therapy at time of service; you will receive information for submission of the claim to your insurance company for direct reimbursement. If your insurance is in network, you will receive a monthly statement with your remainder balance once a reply is received from your insurance company until paid in full. A payment plan can be set up for special circumstances.

MEDICARE PATIENTS: If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible 20 percent. **YES / NO Medicare Secondary Payer form was completed.**

BENEFIT VERIFICATION:

Primary Insurance:___________________________________ Secondary Insurance: ________________________________

CoPay:________________Deductible: __________________ CoPay: _____________ Deductible: ____________________

Out Of Pocket: _________________ Amount Met: _________ Out Of Pocket: ______________ Amount Met: ____________

Estimated Plan Visits Per Year:_________________________

BALANCES DUE AFTER INSURANCE PAYS: If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. Payment arrangements can be made for special circumstances by contacting the office manager within 30 days of the receipt of the invoice. It is your responsibility to make contact with our office to make special arrangements.

EXPLANATION OF BENEFITS:

Service/Supplies	Expected Frequency	Payer	Expected Charges	Patients Potential Financial Responsibility

PAYMENT AT THE TIME OF SERVICE:

I or my Guarantor will be paying for service by Check. Copies of Conservatorship, POA or other legal documents should be provided ($20.00 fee assessed for returned checks).

Life Elevated Therapy is authorized:

- To charge my bank account for services provided under this agreement.
  - Bank Name__________________________Routing_________________Account No.__________________
- To charge my Credit Card for services provided under this agreement.
  - Name on Card:_______________________ Credit Card Number___________________________________
  - Expiration date:_______________________CVV____

Patient or Guarantor Initials: ____________

SELF PAY: If insurance does not cover your therapy and you are a self-paying, all payments will be due at the time services are rendered unless you have made arrangements with the office manager.

DELIQUENT ACCOUNTS: We urge you to keep your account current to avoid any misunderstandings with our office.

PAYMENT ARRANGEMENTS: Under special circumstances, payment arrangements can be made. These arrangements are made with the Office Manager. Our office can set this up for you as a courtesy. You will be sent a monthly statement. It is your responsibility to know your monthly due date, which will be determined at the time of your payment arrangement is set up.

COMMUNICATIONS CONSENT: You agree, in order for us to service your account or to collect any amounts you may owe, that we, or any third-party vendor authorized by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We, or any third-party vendor authorized by Life Elevated Therapy, may also contact you by sending text messages or emails you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

x____/______/______

Patient/Responsible Party Relationship to patient Date

Patient or Guarantor Initials: ____________

MEDICAL RECORD REQUEST FORM

I authorize ____

to disclose the following information from the health record of/ for: ______________________________

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the release of medical and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I may refuse to sign this authorization form. I understand that Life Elevated Therapy will not deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Life Elevated Therapy Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, **it will expire 12 months from the date signed** or as specified: _________________. I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release Life Elevated Therapy, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

x____/_______/_______

Patient/Responsible Party Relationship to patient Date

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the release of medical and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I may refuse to sign this authorization form. I understand that Life Elevated Therapy will not deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Life Elevated Therapy Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, **it will expire 12 months from the date signed** or as specified: _________________. I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release Life Elevated Therapy, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

x____/_______/_______

Patient/Responsible Party Relationship to patient Date

PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: _______________ Phone Number: ________________

Address: ____

____

Dates of Service: From ___________________________To________________________

INFORMATION REQUESTED

[ ] All Pertinent Records [ ] Operative Report [ ] Assessment(s) [ ] Pathology Report [ ] Consultation [ ] X-Ray Films [ ] Discharge Summary [ ] X-Ray Reports [ ] ER Report [ ] Billing Record [ ] History & Physical [ ] Specify: _____________

PURPOSE [**X**] Continuing Medical Care [ ] Attorney Request [ ] Other (specify reason) ____________________________

INFORMATION TO BE GIVEN TO: ____

____

PATIENT QUESTIONNAIRE

Patient Name: ________________________ Date of Birth: ____________________ Today's Date: _________

Phone Number: _______________ Email: _________________ Best way to contact: ☐ Call ☐ Text ☐ Email

Address: ____

Emergency Contact: ____________________________________Phone Number: ______________________

Primary Language: ______________ Height: _______ Weight: ______ Dominant Hand: __________________

Primary Care Doctor or following Neurologists: ____

CONDITION YOU ARE SEEKING TREATMENT FOR:____

____Date of Onset: ________________

*Stroke: Side of body affected: ______________________Type of stroke: _____________________________

*Traumatic Brain or Spinal Cord Injury (TBI or SCI): Date of injury: ___________ Incident: _________________

Did you have surgery? ☐ Yes ☐ No; If YES, date/type of surgery ____

Did your symptoms begin: ☐ Gradually ☐ Suddenly ☐ Other: ____

Have you had therapy for this condition before? ☐ Yes ☐ No; If YES, ☐ PT ☐ OT ☐ Speech ☐ Other: __________

Setting: ☐ Inpatient ☐ Rehab Center ☐ Home Health ☐ Outpatient; Length of care: ________________________

Have you had: ☐ Xray ☐ CT Scan ☐ MRI ☐ VNG ☐ Other: ________ ☐ Result ____________________________

GOALS FOR THERAPY ____

____

____

What recreational activities do you do on a regular basis? ____

Any activities or hobbies you were doing previously? ____

How many days a week are you physically active? ☐ 0 ☐ 1-2 ☐3-5 ☐ 6-7

Occupation ___________________________Hours/week ____________Date last worked _________________

Please rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING (check YES or NO)

Getting in and out of a chair or the car? ☐ Yes ☐ No; If YES, how much:_________________________________

Getting in and out of bed? ☐ Yes ☐ No; If YES, how much:____

Getting dressed/undressed? ☐ Yes ☐ No; If YES, how much: ____

Toileting? ☐ Yes ☐ No; If YES, how much: ____

Showering/ bathing? ☐ Yes ☐ No; If YES, how much: ____

Eating? ☐ Yes ☐ No; If YES, how much: ____

Preparing food/ cooking? ☐ Yes ☐ No; If YES, how much: ____

Going up and down stairs? ☐ Yes ☐ No; If YES, how much: ____

Are you able to drive? ☐ Yes ☐ No; If NO, do you want to drive: _______________________________________

Patient Name: ________________________ Date of Birth: _______________________ Today's Date: _______________

DO ANY OF THE FOLLOWING APPLY (check YES or NO)

Do you experience pain? □ Yes □ No; How long does pain last? _________hours per day _____days/week

Do you have any vision problems? □ Yes □ No; Month/Year of last eye exam: ___________________________

Do you have numbness or tingling? □ Yes □ No; If YES, □ Right □ Left □ Both; location? _______________

Do you smoke? □ Yes □ No; If YES, how often/amount per day: ____

Do you drink alcohol? □ Yes □ No; If YES, how often/amount per day: ___________________________________

Have you had any recent unexplained weight loss? □ Yes □ No

Do you eat vegetables? □ Yes □ No; How many vegetable servings do you eat per day? _________________

Do you drink enough water? □ Yes □ No; How many cups per day? ______________________________________

Do you have any difficulty sleeping? □ Yes □ No; Hours of sleep per night? _____________________________

Do you nap during the day? □ Yes □ No

Are you able to walk? □ Yes □ No; If YES, do you need any assistance: □ Yes □ No

Do you use a cane? □ Yes □ No

Do you use a walker? □ Yes □ No; If YES, □ 2 wheeled □ 3 wheeled □ 4 wheeled

Do you use a leg brace or other device? □ Yes □ No – If YES, what: ___________________________________

Do you use a wheelchair? □ Yes □ No; If YES,□ manual □ automatic

Have you fallen in the past month? □ Yes □ No; If YES, how often: __________________________________

Have you fallen in the past year? □ Yes □ No; Date of last fall or loss of balance: ________________________

Are you fearful of falling? □ Yes □ No

Do you feel off balanced? □ Yes □ No

Have you had any "near falls?" □ Yes □ No

Do you stumble, stagger, or side step while walking? □ Yes □ No

Do you drift to one side when walking? □ Yes □ No; if YES, □ Right □ Left □ Both

Do you feel more off balanced in the dark? □ Yes □ No

Do you feel more unsteady on uneven surfaces? □ Yes □ No

Do you have any cognition/thinking problems? □ Yes □ No

Do you have any voice difficulties? □ Yes □ No

Do you have any difficulty swallowing or coughing when eating? □ Yes □ No

Do you have troubles with pronunciation? □ Yes □ No

Do you have trouble finding words during conversation? □ Yes □ No

Do you have a caregiver? □ Yes □ No; If YES, name and how many hours:_____________________________

Do you experience dizziness? □ Yes □ No; If YES, do symptoms last? □ seconds □ minutes □ hours □ days

do symptoms change with movements/positions? □ Yes □ No; please describe: __________________________

____

Patient Name: ________________________ Date of Birth: _______________________ Today's Date: ________________

Are you currently experiencing any of the following (or in the past week)?

Spinning Sensation?	☐ Yes ☐ No	Severe or recurrent headaches?	☐ Yes ☐ No
Nausea or vomiting?	☐ Yes ☐ No	Lightheadedness?	☐ Yes ☐ No
Ringing in ears?	☐ Yes ☐ No	Fainting while dizzy?	☐ Yes ☐ No
Fullness/pressure in ears?	☐ Yes ☐ No	Dizzy when standing up quickly?	☐ Yes ☐ No
Change in hearing?	☐ Yes ☐ No	Weakness in legs?	☐ Yes ☐ No
Change in vision?	☐ Yes ☐ No	Confusion/memory loss?	☐ Yes ☐ No

Medical History

Diabetes________ ☐ Yes ☐ No	Anxiety________ ☐ Yes ☐ No	Stroke________ ☐ Yes ☐ No
Heart Disease________ ☐ Yes ☐ No	Hearing Problems________ ☐ Yes ☐ No	Back Trouble________ ☐ Yes ☐ No
Heart Surgery ________ ☐ Yes ☐ No	Cancer________ ☐ Yes ☐ No	Whiplash or Neck Trouble_ ☐ Yes ☐ No
Pacemaker/Defibrillator____ ☐ Yes ☐ No	Breathing Trouble________ ☐ Yes ☐ No	Motion Sensitivity________ ☐ Yes ☐ No
High/Low Blood Pressure__ ☐ Yes ☐ No	Meniere's Disease________ ☐ Yes ☐ No	Parkinson's Disease________ ☐ Yes ☐ No
Arthritis ________ ☐ Yes ☐ No	Head Injury or Concussion_ ☐ Yes ☐ No	Other? (please explain)_____________
Migraine________ ☐ Yes ☐ No	Seizures________ ☐ Yes ☐ No	________________________________
Depression________ ☐ Yes ☐ No	TIA________ ☐ Yes ☐ No	________________________________

LIST OF MEDICATIONSURPOSE

Name	Purpose	Time(s) of Day Taken

I hereby acknowledge that the completed information is accurate and filled out to my understanding:

x____/______/_______

Patient/Responsible Party Relationship to patient Date

The Activities-specific Balance Confidence (ABC) Scale*

<u>Instructions to Participants:</u> For each of the following activities, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100% If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports.

0% 10 20 30 40 50 60 70 80 90 100%
No Confidence Completely Confident

How confident are you that you will <u>not</u> lose your balance or become unsteady when you…

1. …walk around the house? _____%
2. …walk up or down stairs? _____%
3. …bend over and pick up a slipper from the front of a closet floor? _____%
4. …reach for a small can off a shelf at eye level? _____%
5. …stand on your tip toes and reach for something above your head? _____%
6. …stand on a chair and reach for something? _____%
7. …sweep the floor? _____%
8. …walk outside the house to a car parked in the driveway? _____%
9. …get into or out of a car? _____%
10. …walk across a parking lot to the mall? _____%
11. …walk up or down a ramp? _____%
12. …walk in a crowded mall where people rapidly walk past you? _____%
13. …are bumped into by people as you walk through the mall? _____%
14. …step onto or off of an escalator while you are holding onto a railing? _____%
15. …step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. …walk outside on icy sidewalks? _____%

Total ABC Score: __________

***Scoring: _____________ / 16 =** __________% of self confidence*

***MEDICARE PATIENTS ONLY** 100% - _____% Function = _____% Impairment*

*Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1):M28-34.

Lower Extremity Functional Scale (LEFS)

Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework or school activities.	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3. Getting into or out of the bath.	0	1	2	3	4
4. Walking between rooms.	0	1	2	3	4
5. Putting on your shoes or socks.	0	1	2	3	4
6. Squatting.	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8. Performing light activities around your home.	0	1	2	3	4
9. Performing heavy activities around your home.	0	1	2	3	4
10. Getting into or out of a car.	0	1	2	3	4
11. Walking 2 blocks.	0	1	2	3	4
12. Walking a mile.	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14. Standing for 1 hour.	0	1	2	3	4
15. Sitting for 1 hour.	0	1	2	3	4
16. Running on even ground.	0	1	2	3	4
17. Running on uneven ground.	0	1	2	3	4
18. Making sharp turns while running fast.	0	1	2	3	4
19. Hopping.	0	1	2	3	4
20. Rolling over in bed.	0	1	2	3	4
Column Totals:	______	______	______	______	______

Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. Phys Ther. 1999 Apr;79(4):371-83.

% of maximal function = (LEFS score) / 80 * 100 The minimal clinically important difference is 9 scale points. Lower the score the greater the disability.