AK FITNESS THERAPY CENTER

PATIENT INFORMATION

First Name: _____ Last Name: _____

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

Date of Birth: _____ Social Security: _____ Home #: _____

Cell #: _____ Fax #: _____ Email: _____

Gender: M or F Height: _____ Weight: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work #: _____

Marital Status: Single Married Separated Divorced Widowed

Spouse Name: _____

Emergency Contact: _____ Phone #: _____

Referring Physician: _____

(1) I give permission for a message to be left on my answering machine/ voice mail.
(2) I give permission for the following person to obtain information concerning my treatments and/or billing.

_____ _____

NAME RELATIONSHIP

Print Name: _____ Date: _____

Signature: _____

NOTICE ARE YOU CURRENTLY OR HAVE YOU IN THE LAST (3) MONTHS RECEIVED ANY HOME HEALTH?

YES _____ NO _____ HOME HEALTH AGENCIES NAME: _____

NUMBER: _____

AK FITNESS THERAPY CENTER

INSURANCE INFORMATION

Name of Card Holder: _____

SS # of Card Holder: _____ DOB: _____

Relationship to patient: _____

Insurance Name: _____

Group Plan #: _____ Policy #: _____

WORKER'S COMP:

Company Name: _____

Adjustor Name: _____

Phone #: _____ Fax #: _____

Claim #: _____ DOI: _____

AUTO ACCIDENT:

Date of Accident: _____ State accident in: _____

Attorney: _____

Contact: _____

Phone: _____

(1) I hereby authorize the acting licensed Physical Therapist to evaluate and treat me as needed.
(2) I hereby authorize and request AK Fitness Therapy Center to release my complete medical records to my insurance companies and I hereby assign AK Fitness Therapy Center all my payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not paid by my insurance.
(3) All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to AK Fitness Therapy Center.
(4) We encourage all of our patients to call their insurance company for a better understanding of their Out Patient Physical Therapy benefits.
(5) If you have a copay, a payment will be due after each treatment.

DATE: _____ SIGNATURE: _____

Exhibit # 6

A K FITNESS THERAPY CENTER

Patient's Name: Date:

PART 1

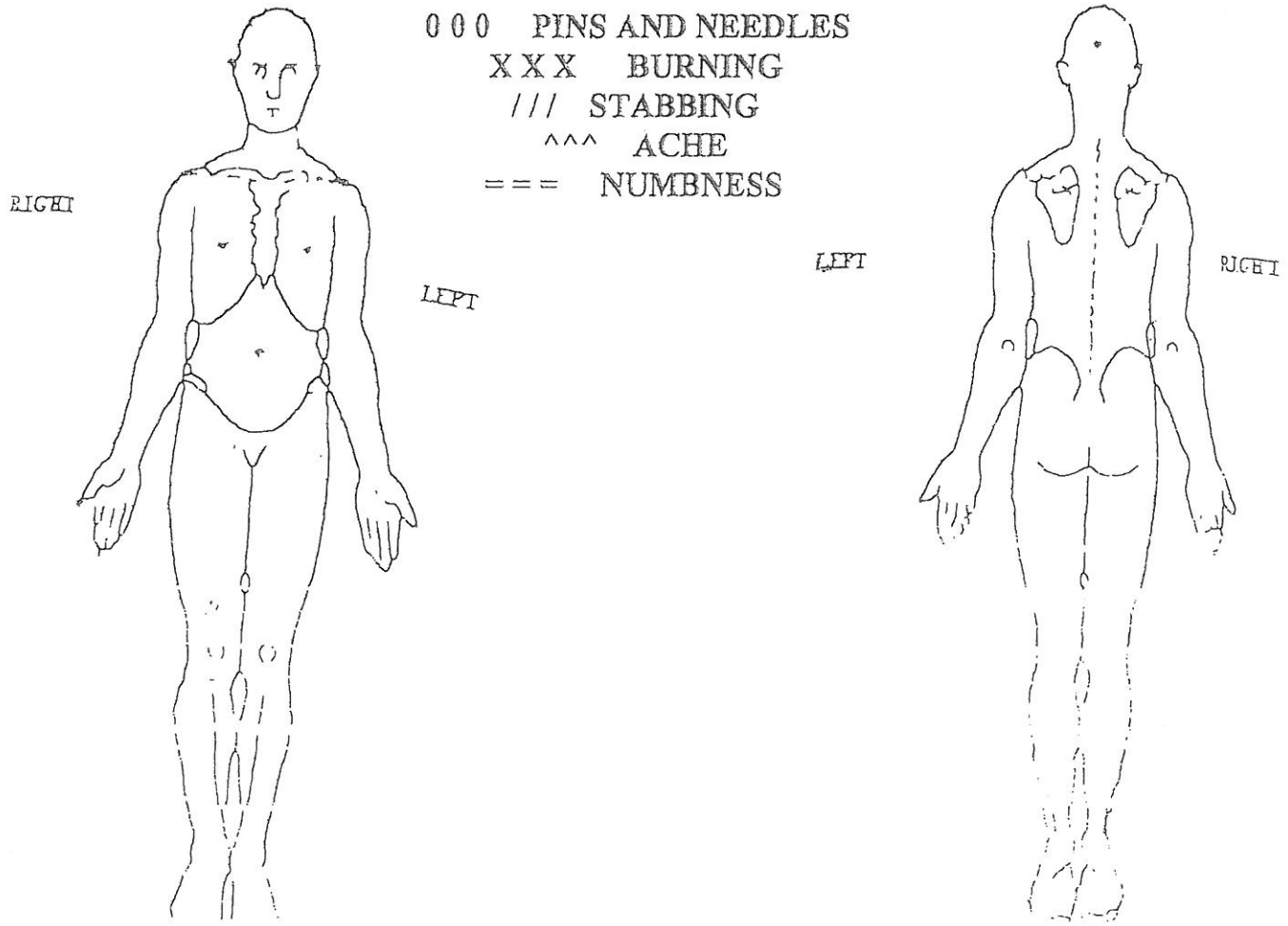
USING THE PAIN SCALE, PLACE, AND A NUMBER IN EACH BOX FOR HOW MUCH PAIN YOU ARE HAVING.

0 1 2 3 4 5 6 7 8 9 10

NOW	BEST IN THE PAST 30 DAYS	WORST IN THE PAST 30 DAYS

NORMAL: 0
LOW: 1, 2, or 3
MODERATE: 7, 8, or 9
EMERGENCY: 10

INDICATE THE TYPE OF PAIN AND LOCATION BY USING THE SYMBOLS BELOW



PATIENT MEDICAL HISTORY FORM

Name:_____ Treating Physician:_____ Primary Care Physician: _____
Date of 1st Doctors Visit for this Injury:_____ Last Day Worked Due to this Injury (if applicable):_ Date
Returned to Work after Injury (if applicable):_____ Have you retained an attorney as a result of your injury? YES NO
Referral Source: Surgeon Rehab MD Other:_____
Have you had Surgery for this Injury? YES NO Number of Surgeries:_____ Type of Surgery(ies):_____

Are you currently taking any medications (prescription and/or over the counter medicines):

Anti-Inflammatories	YES	NO	If YES, please specify:_____
Muscle Relaxers	YES	NO	If YES, please specify:_____
Pain Medication	YES	NO	If YES, please specify:_____
Other	YES	NO	If YES, please specify:_____

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode

	YES	NO		YES	NO
Chiropractor	____	____	General Practitioner	____	____
EMG/NCV	____	____	CT Scan	____	____
Massage Therapy	____	____	MRI	____	____
Myelogram	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room	____	____	X-Rays	____	____

Do you now or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	High Blood Pressure	____	____
Anemia	____	____	Shortness of Breath/Chest Pain	____	____
Heart Attack or Surgery	____	____	Diabetes	____	____
Coronary Heart Disease or Angina	____	____	Thyroid Trouble/Goiter	____	____
Gout	____	____	Cancer/chemotherapy/Radiation	____	____
Dizziness or Fainting	____	____	Weakness	____	____
Emotional/Psychological Problems	____	____	Infectious Diseases	____	____
Hernia	____	____	Bowel or Bladder Problems	____	____
Numbness or Tingling	____	____	Allergies	____	____
Severe or Frequent Headaches	____	____	Elbow/Hand Injury	____	____
Osteoporosis	____	____	Vision or Hearing Difficulties	____	____
Neck Injury/Surgery	____	____	Stroke/TIA	____	____
Sleeping Problems/Difficulties	____	____	Back Injury/Surgery	____	____
Blood Clot/Emboli	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Knee Injury/Surgery	____	____	Epilepsy/Seizures	____	____
Do you have a Pacemaker?	____	____	Arthritis/Swollen Joints	____	____
Varicose Veins	____	____	Any Pins or Metal Implants?	____	____
Are You Pregnant?	____	____	Joint Replacement	____	____
Weight Loss/Energy Loss	____	____	Do You Smoke?	____	____

Please list any additional information that would assist us in providing care to you? _____

Are you aware of your diagnosis (what you are being treated for at our clinic)? Yes No

What are your expectations/goals? _____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature:_____ **Date:** _____
Patient/Legal Guardian Name: _____
Therapist's Signature:_____ **Date:** _____

AK FITNESS HEALTH CENTER INC.

ATTENTION MEDICARE PART- B PATIENTS

Effective Now the Therapy Cap will be applied to all Part- B outpatient therapy
Including: *Home Health Agencies (TOB 34X)
*Private Parties
*Part B Skilled Nursing Facilities
*Out patient Rehabilitation Facilities (ORFs)
*Rehabilitation Agencies (Comprehensive Outpatient Rehabilitation Facilities- CORFS)
*Hospital Outpatient Departments (HOPDS)

NAME: _____
NUMBER: _____

TOTAL MEDICARE CAP FOR ALL THESE COMBINED SERVICES $3,700.00

HAVE YOU RECEIVED ANY OF THESE SERVICES AND HAVE YOU REACHED THE OVER ALL MEDICARE PART- B CAP. YES _____ OR NO _____

CHARGES FROM AK FITNESS HEALTH CENTER INC WILL BE YOUR RESPONSIBILTY.

IF YOU ONLY HAVE MEDICARE AS YOUR INSURANCE PLEASE BE AWARE THAT MEDICARE WILL ONLY PAY 80% OF YOUR PHYSICAL THERAPY TREATMENTS, AND YOU WILL BE RESPONSIBLE FOR THE OTHER 20%.

IF YOU ARE NOT FINANCIALLY ABLE TO PAY THE 20%, PLEASE MAKE US AWARE AND WE ASSIST YOU WITH OUR PAYMENT PLAN OF $25.00 A MONTH UNTIL PAYMENT IS PAID IN FULL.

IF YOU UNDERSTAND THE ABOVE INFORMATION OR HAVE QUESTIONS PLEASE DO SO BEFORE SIGNING THIS FORM.

SIGNATURE: _____

SPOUSE: _____

DATE: _____

AK FITNESS THERAPY CENTER

2903 Judson Rd

Longview, TX 75605

903-663-6332

FAX: 903-663-6347

ATTENTION ALL PATIENTS

YOU are responsible for notifying us of any changes to your insurance and providing us with a current copy of your insurance card(s). This also means that if your Insurance Company changes you will let us know and provide a copy of your new insurance card. If for any reason you neglect to notify us of changes, you will be liable for any and all charges incurred that your prior or present insurance companies will not cover.

Please sign and date letting us know that you have acknowledged the above statement and you understand and agree to these terms.

Patient Name (print): _____

Patient Name (sign): _____

Date: _____

AK FITNESS THERAPY CENTER

NOTICE OF PRIVACY PRACTICE

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

USES AND DISCLOSURES TREATMENT: Your health information may be used by staff members or disclosed to other healthcare professionals for the purposes of evaluating your health and diagnosis medical conditions. Laboratory tests and procedures will be available in your medical record to all health professionals who may be consulted by staff members.

PAYMENT: Your health information may be used to see payment from your health plan, from other sources of coverage such as an automobile insurer, from credit card companies that you may use to pay for services provided and the medical condition being treated.

HEALTH CARE OPERATIONS: Your health care information may use as necessary to support the day to day activities and management of AK FITNESS THERAPY. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards and they include:
The right to request restriction on the use and disclosure of your protected health information.
The right to receive confidential communications concerning your medical condition and treatment.
The right to inspect and request a copy of your protected health information.
The right to amend or submit corrections to your protected health information.
The right to receive an accounting of how and to whom our protected health information has been disclosed.
The right to receive a printed copy of notice.

AK FITNESS THERAPY'S DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices that are outlined in this notice.
Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices so that they conform to federal and state laws and regulations. Whatever the reasons for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. Request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting us.

IF YOU WOULD LIKE TO INQUIRE FURTHER ABOUT OUR PRIVACY PRACTICES OR SUBMIT A COMMENT YOU MAY DO SO AT THE FOLLOWING ADDRESS.

HIPAA PRIVACY PRACTICE
AK FITNESS THERAPY CENTER
2903 JUDSON ROAD
LONGVIEW, TX 75605

If you believe your privacy rights have been violated, please contact us at the above address.

PATIENT'S INITIALS

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.