Release & Waiver

Synergy Studio

I, _____, have enrolled in a program of physical activity, including but not limited to, body conditioning machinery used during the workouts offered by Synergy Studio. I affirm that I am in good physical condition and do not suffer from any disability that would contribute to injury. Furthermore, I understand and agree with the following:

1. I assume full responsibility while voluntarily participating in any training and /or exercise class at my sole risk and shall abide by any and all rules and regulations for use of the facility which may be altered and publicized from time to time by its owner or Synergy Studio.

2. I am aware that there exists the possibility of certain conditions occurring during or following training and /or exercise. These conditions include, but are not limited to: mild or light headedness, fainting, abnormalities of blood pressure or heart rate, ineffective heart function and in rare instances, heart attack and stroke. The reaction of the cardiovascular system to such activity cannot be predicted with complete accuracy.

3. It is strongly recommended that I receive medical clearance from my private physician prior to starting this or any exercise training program. This program can be designed for persons with known heart disease or those with disorders, which can require medical supervision however, those persons should have a direct physician referral. Synergy Studio reserves the right to deny services to those without written consent/referral from their physician.

4. I expressly agree that I have been informed that the program involves possible risks and all exercises shall be undertaken at my sole risk and that neither Synergy Studio, nor the officers, directors, agents or employees shall be liable to me nor any other person, for any claims, demands, injuries, damages, actions or causes of action, whatsoever, to my person or property arising out of or connected to services and/or exercises having direct or indirect relation to this facility, and not resulting from the negligence of Synergy Studio or its officers, directors, agents or employees.

5. I am aware students participating in the Synergy Studio Polestar Education Programs may observe classes and I may decline observation in a private session.

6. I give consent to Synergy Studio, and its subsidiaries and affiliates, to use photographs free of charge, in connection with any and all promotions; including but not limited to video, photography, mailings, or internet pages created by and for Synergy Studio, and used by them for promotional videos, internet use, slide presentations, advertising or brochure inclusion.

*This release & waiver will NOT expire. Client personal information obtained on Health & Fitness Form

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THE CONDITIONS

Client Signature: _____ Date: _____

Witness: _____ Date: _____

In case of emergency, please contact: _____

Emergency phone number(s): _____

Cancellation & Late Arrival Policy
Synergy Studio

I. Cancellation Policy

Cancellation of a scheduled appointment must be at least twenty four (24) hours before the scheduled appointment time. This includes exercise/training sessions as well as rehabilitation sessions. Failure to provide sufficient notice may result in the assessment of a cancellation charge in the full amount of the scheduled service.

II. Late Arrival Policy

In order to service all clients in a punctual manner, Synergy Studio and its instructors reserve the right to decrease the service time of a client who arrives late for a scheduled appointment. The time adjustment shall be commensurate with the delay of the start time in order to accommodate the next scheduled client. There will be no adjustment of the fee for the scheduled service.

I have read and understand the cancellation and late policies of Synergy Studio and by my signature agree to uphold my obligations as stated above.

Signed: _____ Date: _____

Health and Fitness History

Synergy Studio

Please fill out this form to the best of your ability and sign at the bottom of the form. If you have any questions please feel free to ask.

Name: _____ Birth date: _____ Date: _____

Address: _____

Street City Zip Code

Home Phone: _____Work Phone: _____Cell Phone: _____Email: _____

Employer: _____Occupation:_____

How long is your work day?_____ Is your job physically or mentally demanding?_____

Sex: M/F Marital Status:_____ General Health: _____Excellent _____Good _____Fair _____Poor

Previous experience with Pilates:_____

Personal Goals:_____

Medications:_____

Previous Injuries:_____

Previous Surgeries:_____

Are you currently experiencing any physical problems? If so, please explain: _____

_____

Are you currently receiving professional health care services? If so, please explain: _____

_____

Date of you last doctor's visit: __ _____Do you smoke? Yes/No If yes, how much? _____

Has your doctor indicated any limitations or exclusions of certain activities? Describe: _____

_____

Are you currently or have you previously been diagnosed with any of the following?

Arthritis	Yes	No	Herniated Disc	Yes	No
Back Pain	Yes	No	High Blood Pressure	Yes	No
Cancer	Yes	No	Hypoglycemia	Yes	No
Carpal Tunnel Syndrome	Yes	No	Numbness	Yes	No
Circulatory Disease	Yes	No	Osteoporosis	Yes	No
Diabetes	Yes	No	Pelvic Floor Pain/Weakness	Yes	No
Dizziness	Yes	No	Pregnancy	Yes	No
Fainting	Yes	No	Seizure Disorder	Yes	No
Fibromyalgia	Yes	No	Shoulder Impingement	Yes	No
Heart Disease	Yes	No	Stenosis	Yes	No

How did you hear about us? _____

Is there anything that you feel we should know and have not asked? If so, please explain: _____

_____

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____DATE: _____

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Synergy Studio reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **Synergy Studio.**

Name of Patient _____

Signature of Patient _____

Date _____

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

_____

Synergy Studio
3576 St. Johns Avenue
Jacksonville, FL 32205

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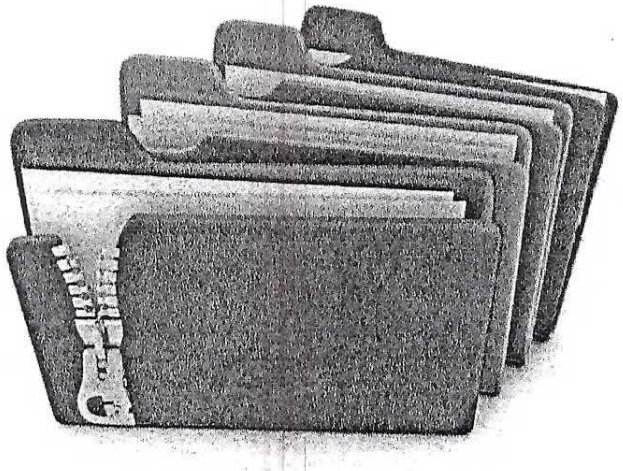
904.387.6701 fax
www.synergystudiopt.com
synergystudio@bellsouth.net



Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Instruction C: Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

Instruction G: If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Lynn Peterson, PT, CPT-PMA®
Synergy Studio Owner
904.387.9355/synergystudio@bellsouth.net

To ensure you receive a complete and thorough evaluation, please provide us with the important background information requested in the following form. **If a question is not clear, please leave it blank and your therapist will assist you.** Thank you for choosing Synergy Studio.

Name: _____Address:_____

Reason for Physical Therapy _____

Occupation: _____ Primary or Referring MD: _____

Date of Birth:_____ Daytime Phone:_____ Mobile Phone:_____

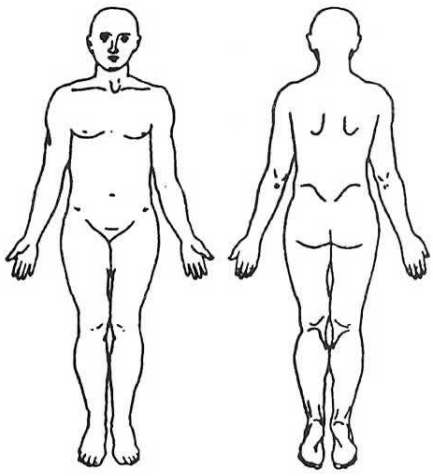
Email address: _____ How did you hear about us?_____

Please check any of the following health professionals whose care you are currently under.

___Medical Doctor ___Osteopath ___Chiropractor ___Dentist ___Psychiatrist/Psychologist

___Physical Therapist ___Occupational Therapist Other _____

Please indicate the **location** of your symptoms on the diagram to the right by shading in the area of symptoms.



Please indicate the **level of pain** on a scale of 0 to 10 with 0 representing no pain and 10 representing the level of pain that would make you seek emergency care

.

Pain in the last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Average pain the past week: 0 1 2 3 4 5 6 7 8 9 10

Date of onset of symptoms :_____

Brief description of symptoms: _____

How did your symptoms start?:_____

List your leisure activities: _____

Frequency of exercise: Daily 3 times weekly Once a week

YES NO Exercise provokes symptoms. When was the last time you exercised? _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Have you carried any pregnancies to term? YES NO If YES, how many: _____

Have you **recently** noted any of the following:

YES NO Weight loss/gain

YES NO Dizziness/lightheadedness

YES NO Weakness

YES NO Numbness or tingling

YES NO Nausea/Vomiting

YES NO Fatigue

YES NO Fever/chills/sweats

YES NO Vision changes (ie. new glasses)

Have you **ever** been diagnosed as having any of the following conditions?

YES NO Cancer If YES, what kind: _____ Date diagnosed:_____

YES NO Heart Problems
YES NO Circulation Problems
YES NO Emphysema/Bronchitis
YES NO Thyroid Problems
YES NO Rheumatoid Arthritis
YES NO Osteoporosis/Osteopenia
YES NO Multiple Sclerosis
YES NO Kidney disease
YES NO Hepatitis
YES NO Stroke

YES NO High Blood Pressure
YES NO Asthma
YES NO Chemical Dependency (ie. alcoholism)
YES NO Diabetes If YES, Type 1 or 2
YES NO Other Arthritic Conditions
YES NO Urinary or Fecal Incontinence
YES NO Depression
YES NO Anemia
YES NO Tuberculosis
YES NO Epilepsy

Describe any illness diagnosed by a physician not in the list _____

Please list any surgeries or hospitalizations you have had in the past:

	DATE	REASON FOR SURGERY/HOSPITALIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please describe any **significant injuries** for which you have been treated (ie.sprains, fractures)

	DATE	INJURY
1.	_____	_____
2.	_____	_____
3.	_____	_____

Has anyone in your immediate family (parents, siblings) ever been treated for the following?

YES NO Diabetes
YES NO Kidney Disease
YES NO Headaches
YES NO Cancer
YES NO Arthritis
YES NO Tuberculosis
YES NO Heart disease
YES NO Anemia
YES NO Mental Illness

Which of the following over the counter medications have you taken in the past week?

YES NO Aspirin
YES NO Laxatives
YES NO Antacids
YES NO Tylenol
YES NO Decongestants
YES NO Vitamins/ Mineral Supplements
YES NO Advil/Motrin/Ibuprofen
YES NO Antihistamines

YES NO Other including herbal/homeopathic _____

Please list any prescription medications that you are currently taking:

_____

_____

ALLERGIES: List any medications you are allergic to:_____

Are you latex sensitive? Yes No Any other allergies we should know about? _____

YES NO Do you drink caffeinated beverages? If YES, how much caffeinated coffee or caffeine containing beverages do you drink per day?_____ How many days per week? _____

YES NO Do you drink alcoholic beverages? If YES, and one drink equals one beer or glass of wine, how much do you drink at an average sitting?_____ How many days per week?_____

YES NO Do you smoke? If YES, How many packs of cigarettes do you smoke in a day?_____

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you experienced little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home, has anyone hit you or tried to injure you in any way? YES NO

Patient Signature_____ Date_____

Therapist Signature_____Date_____

Thank you for your cooperation in the completion of this form. You are welcome to add any further information that was not specifically requested above but you feel is important to share with the therapist in the space below.

Please fill out the form on the back of this page if you have requested to have your insurance company billed for your therapy through our billing service.

New Patient Information Sheet

Patient Information

Name :(First) _____ (MI) ____ (Last) _____

Date of Birth_____ Age ____ Sex M F Marital Status: S M W D

Address: Street _____

City_____ State _____ Zip _____

Phone #: _____ SS#: _____ DL# _____

Work #: _____ Employer: _____

Employer's Address: _____

Referring Physician: _____

If Student, School Name: _____

Insurance Information

Insurance Co: _____ Phone # _____

Insurance Address: _____

Group # _____ Certificate/ID # _____

Insured's Name: _____ Relationship to Patient: Self Spouse Dependent

Insured's Employer: _____ Phone # _____

Employer's Address: _____

Insured's SS # _____ Date of Birth: _____ Sex: M F

I hereby assign, transfer, and set over to Synergy Studio all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____ Date: _____