PRIME FITNESS PHYSICAL THERAPY & REHABILITATION

Tel: (718)676-4112 Fax: (718)676-4134

2952 Brighton 3rd Street, Brooklyn NY 11235

https://primefitnessphysicaltherapy.com

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

I. PATIENT DEMOGRAPHICS

Last Name:_____ First Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____)_____ Email: _____
Age: _____ Date of Birth: _____ Sex: M ___ F ___ SS# _____-_____-_____
Marital Status: S____ M_____ D_____ W_____ Spouse Name: _____
Primary Care Physician:_____
Address:_____ Phone: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____ Last Time Received Physical Service___/_____ /____

II. THIS INFORMATION MUST BE COMPLETED BY ALL INSURED PATIENTS UNLESS ☐ - SELF PAY

Insured's Name: _____ Insureds SS# _____-_____-_____
Patient's Relationship to Insured: __Self __Spouse __Child Insurance Company: _____
Insurance ID#: _____ Insurance Group #:_____
Address: _____ Phone: _____
Referred By: _____ Referred Phone: _____

III. SECONDARY INSURANCE

Insured's Name: : _____ Insured's SS#: _____ - _____ - _____
Patient Relationship To Insured: ___Self ___ Spouse ___ Child Insurance Company: _____
Insurance ID #: _____ Insurance Group #: _____
Address: _____ Phone: _____
Are you currently working? Yes/No Limited Duty: _____

IV. INJURY INFORMATION

Where did the injury occur: Work: _____ Car Accident: ____ Other: _____ Date of Accident: _____
Do you have an attorney? Yes ☐ No ☐: Attorney: _____ Phone: _____
How did injury occur? _____

CONTINUED ON THE NEXT PAGE

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V. WORKERS COMPENSATION CASE ☐

Carrier Name: _____

Case #: _____ WCB #: _____

Adjuster Name: _____ Phone: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Have you received prior Physical Therapy services for this problem this year?

☐ Yes – Frequency & duration: _____ ☐ No

VI. NO FAULT CASE: ☐

Insurance Name: _____

NF Claim #: _____

Policy #: _____

Adjuster Name: _____ Adjuster Phone: _____

Have you received prior Physical Therapy services for this problem this year?

☐ Yes – Frequency & duration: _____ ☐ No

Please note: If you are a worker compensation or motor vehicle accident patient, and you have personal health insurance, we require that you supply us with the secondary information in the event that workers compensation or the motor vehicle insurance would deny your claim. If you choose not to provide your personal health carrier information, please be aware that you will be responsible for any outstanding balance that may arise from a denial. Initials _____

I, _____ confirm that the information provided above is accurate and current and if anything should change in this section, I will alert Prime Fitness Physical Therapy, LLC. I understand that failure to provide must current, honest and accurate information will result in my financial responsibility for services rendered at Prime Fitness Physical Therapy, LLC.

Signature: _____ Date: _____
(patient signature)

Signature: _____ Date: _____
(parent/legal guardian signature)

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PATIENT MEDICAL HISTORY

Do you smoke? Yes _____ No _____ Are you Pregnant? Yes _____ No _____

Medical History – Mark one box for each item

	No	Yes – Under a year	Yes – Over a year		No	Yes – Under a year	Yes – Over a year
Allergy to Latex				Allergy to Other			
Angina				Arthritis			
Back Injuries				Balance Problems			
Bladder/Bowel Problems				Blood Clot/DVT			
Blurred/Double Vision				Breathing Difficulties/Asthma			
Cancer				Chest pain			
Chronic Pain/Headaches				Circulation/Vascular Problems			
Constant Unrelieved Pain				Diabetes			
Difficulty Sleeping				Difficulty Swallowing			
Dislocation				Dizziness/Faintness			
Double Vision				Emotional Problems			
Epilepsy				Falls			
Fever/Nausea				Fractures			
Gastrointestinal Problems				Gout			
Groin Numbness				Head Injury			
Heart Attach				Heart Disease			
Heart Surgery				High Blood Pressure			
Jaw Injuries				Kidney Condition/Disease			
Lung Disease				Metal Implants			
Muscular Pain				Neck Injuries			
Nervous Problems				Nigh Sweats/Night Pain			
Obesity				Osteoporosis			
Pacemaker				Peripheral Neuropathy			
Psychological Condition				Ringing in Ears			
Seizures				Shortness of Breath			
Smoking				Stroke			
Tingling/Numbness				Tremors			
Tumors				Unexplained Weight Loss			
Unexplained Weight Loss				Unusual Fatigue/Weakness			

Have you fallen within the past year? Yes/No If so, how many times? _____

List all medications you are currently taking: _____

Describe your problem/reason for visit: _____

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How did your symptoms begin? _____

PAIN: Please Rate Your Pain from 0-10: 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10 ____

Check which best describes your pain

_____ Constant	_____ Decreasing	_____ Dull/Achy	_____ Increasing
_____ Intromittent	_____ Night Pain	_____ Occasional	_____ Pain Upon Waking
_____ Sharp Pain	_____ Static	_____ Stiffness	

Pain is aggravated by: _____ Pain is eased by: _____

How would you rate your ability to perform routine daily activities (circle)?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How would you rate your ability to perform the activities associated with your job?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

List any major surgeries and hospitalizations:

_____- Date: _____

_____- Date: _____

I, _____ have provided all of the above information to the best of my knowledge at
(patient printed name)
the time of this visit and will notify this office if any information above has changed during the care of Prime Fitness Physical Therapy, P.C.

Signature: _____ Date: _____
(patient signature)

Signature: _____ Date: _____
(parent/legal guardian signature)

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Treatment Agreement

_____**TREATMENT CONSENT**: I hereby authorize Prime Fitness Physical Therapy, PC, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition.

_____**AUTHORIZATION TO RELEASE OF INFORMATION:** I further authorize Prime Fitness Physical Therapy, PC to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text messages or email. I acknowledge that Prime Fitness Physical Therapy, PC is released from all legal liability that may arise from release of my medical records.

_____**ASSIGNMENT OF BENEFITS:** I agree to assign my therapy benefits to Prime Fitness Physical Therapy, PC for the services in which I receive and authorize my insurance carrier to make payments to Prime Fitness Physical Therapy, PC on my behalf. it is my responsibility to inform the facility of changes to my insurance and policy as well as name, address and phone changes.

_____**FINANCIAL RESPONSIBILITY:** I understand that I am responsible for payment of my account and the facility. I hereby do guarantee payment in full on my account with Prime Fitness Physical Therapy, PC, LLC for treatments and services rendered and does not take responsibility for negotiating settlements of disputed claims. I understand that all co-payments, deductible, and/or coinsurance is to be paid at time services are rendered. All balances that accrue after the initial insurance payment is received, is due upon receipt. If the account be referred to an attorney for collections, the undersigned agrees to pay all attorney's fees, court costs, legal and lawful collections costs in addition to all other sums due.

_____**ASSIGNMENTS AND AUTHORIZATION TO BILL MEDICARE:** If I am a patient covered under Medicare/ Medicaid program, I understand that I am responsible for 20% of Medicare Part B services. I hereby assign and authorize payment to be made directly to Prime Fitness Physical Therapy, PC, LLC, herein not to exceed the Facilities regular charges for this treatment.

_____**SELF PAY:** It is our policy that you will be treated fairly and with respect regardless of your ability to pay for the services you received. If you don't qualify for local Health Assist programs, you'll be offered a prompt pay discount. We also provide reasonable, interest-free payment arrangements. Prime Fitness Physical Therapy, PC reserves the right to seek reimbursement from and all your insurers regardless if weather you provide us with their contact information, unless you instruct us to bill us directly. All records released require an administrative and copying fee paid to Prime Fitness Physical Therapy, PC before they are release, regardless of requestor. Prime Fitness Physical Therapy, PC is HIPAA compliant with regard to information sharing polices.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

I consent to Prime Fitness Physical Therapy, PC releasing my protected health information to the following individuals:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

Patient Name Printed: _____ Date: _____
Patient Name Signed: _____ Date: _____
Guardian/Parent Printed Name: _____ Date: _____
Guardian/Parent Signature: _____ Date: _____
Witness Signature: _____ Date: _____

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NEW YORK MOTOR VEHICLE INSURANCE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

For Accidents occurring on and after 3/1/2002
Claim Number: _____

I, _____, ("Assignor") hereby assign to **Prime Fitness Physical Therapy, PC.** ("Assignee")
(Print patient's name) (Provider Name)
all rights, privileges and remedies to payment for health care services provide by the Assignee to which I am entitled under Article 51 (the No-Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on the behalf Assignor and shall not pursue payment directly from the assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary.
(Print date)
This agreement maybe revoked by the Assignee when benefits are not payable based upon the Assignor's lack of coverage and or violation of a policy condition due to the actions or conduct of the Assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCELAS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL COMITS A FRAUDULENT INSURNACE ACT, WHICH IS A CRIME, AND SHALL ALSO SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____
(Print Patient Name)

_____
(Patient Signature)

_____
(Date of Signature)

_____
(Provider Name)

_____
(Provider Signature)

_____
(Date of Signature

_____
(Patient Address)

_____
(Patient Address Continued)

Prime Fitness Physical Therapy PC
(Provider Address)

2952 Brighton 3rd Street, Brooklyn NY 11235
(Provider Address Continued)

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PRIVACY POLICY NOTICE

THIS NOTICE DISCLOSES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Last Updated May 11, 2019

1. Privacy Policy Overview

Prime Fitness Physical Therapy, PC is required by law to protect the privacy of your health information that may reveal your identity, and to provide individuals with notice of its legal duties and privacy practices with respect to health information Prime Fitness Physical Therapy, PC is required to abide by the terms of the Notice currently in effect. You will also be able to obtain your own copy by calling our office at (718)676-4112 or asking for one at the time of your next visit. Prime Fitness Physical Therapy, PC reserves the right to change the terms of its notice and to make the new notice provisions effective for all PHI that it maintains.

This Notice of Privacy Practices and Policies outlines our practices, policies and legal duties to maintain confidentiality and protect against prohibited disclosure of protected health information ("PHI") under the privacy regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI includes your demographic information such as name, address, telephone number, and family; past, present, or future information about your physical or mental health or condition; and information about the medical services provided to you, including payment information, if any of that information may be used to identify you. Your PHI may be maintained by us electronically and/or on paper.

This Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We may amend this Notice of Privacy Practices and Policies periodically. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices or you may obtain a copy by accessing our website at info@primefitnessphysicaltherapy.com or by calling the office, (718)676-4112 and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with Prime Fitness Physical Therapy, PC

If you have any questions about Prime Fitness Physical Therapy, PC Notice of Privacy Practices and Policies, please contact Elena Vaynshtok, DPT at (718)676-4112 or via email at info@primefitnessphysicaltherapy.com

2. Safeguarding PHI within our Practice

We have in place appropriate administrative, technical, and physical safeguards to protect and to secure the privacy and security of your PHI. We orient our staff to the regulations and policies developed to protect the privacy of your PHI and review their obligation to maintain privacy and security annually. We hold medical records in a secure area within our practice, and our electronic medical record system is monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only staff members who have a legitimate "need to know" are permitted access to your medical records and other PHI. Our staff understands the legal and ethical obligation to protect your PHI and that a violation of this Notice of Privacy Practices and Policies may result in disciplinary action in accordance with our Human Resource policies.

3. **Uses and Disclosures of PHI**

As part of our registration materials, we will request your "written consent" for our practice to use and disclose your PHI for the following types of activities:

- **Treatment.** Treatment means the provision, coordination, or management of your health care and related services by Prime Fitness Physical Therapy, PC and health care providers involved in your care. It includes the coordination or management of health care by a provider with a third-party insurance carrier, communication with lab or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care, or our referral of you to a specialist physician or facility. We can use our health information and share it with other professionals who are treating you given consent such as a physician treating you for an injury asks us about your overall health condition.
- **Payment.** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment also may include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.
- **Health Care Operations.** Health care operations mean the legitimate business activities of our practice. These activities may include quality assessment and improvement activities; fraud & abuse compliance; business planning & development; and business management & general administrative activities. These can also include our telephoning you to remind you of appointments or using a translator if we need to communicate with you in person, or on the telephone, in a language other than English.

When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. **Electronic Exchange of PHI**

We may transfer your PHI to other treating health care providers electronically. We may also transmit your information to your insurance carrier electronically.

5. **Uses and Disclosures of PHI Based Upon Your Written Authorization**

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that Prime Fitness Physical Therapy, PC disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment, or health care operations, such as a family member or a school physical education program. If you wish us to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

6. **Uses and Disclosures of PHI Permitted or Required by Law**

In some circumstances, we may be legally bound to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to:

- **Emergencies.** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Others Involved in Your Healthcare:** Upon your verbal authorization, we may disclose to a family member, close friend or other person you designate only that PHI that directly relates to that individual's involvement in your healthcare and treatment.

We may also need to use PHI to notify a family member, personal representative or someone else responsible for your care of your location and general condition.

- **Communication barriers.** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to the use or disclosure, or the physician determines that a limited disclosure is in your best interests, Prime Fitness Physical Therapy, PC may permit the use or disclosure.
- **Required by Law:** We may disclose your PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public Health/Regulatory Activities:** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to the appropriate regulatory agency.
- **Food and Drug Administration:** We may disclose your PHI to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations as well as to track product usage, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance.
- **Health oversight activities.** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.
- **Judicial and administrative proceedings.** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with specific statutory obligation compelling us to do so, or with your permission.
- **Law enforcement activities.** In accordance with Vermont state law, we may not disclose your PHI to a law enforcement officer for law enforcement purposes without court order, statutory obligation or patient authorization.
- **Coroners, medical examiners, funeral directors and organ donation organizations:** We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other lawful duties. We also may disclose your PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.
- **Research.** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure the privacy of your PHI.
- **Serious threats to health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military activity & national security.** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military command authorities to assure proper execution of the military mission. We also may disclose your PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation:** We may disclose your PHI as authorized to comply with worker's compensation law.
- **Inmates of a Correctional Facility:** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received your PHI in the course of providing care to you while in custody.
- **US Department of Health and Human Services:** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health & Human Services to investigate or determine our compliance with the privacy laws.
- **Disaster Relief Activities:** We may disclose your PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).

7. **Your Rights Regarding PHI**

- **Right to request restriction of uses and disclosures.** You have the right to request that we not use or disclose any part of your PHI unless it is a use or disclosure required by law. Please advise us of the specific PHI you wish restricted and the individual(s) who should not receive the restricted PHI. We are not required to agree to your restriction request, with one exception*, but if we do agree to the request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. In that

case, we will ask that the recipient not further use or disclose the restricted PHI. You may request restrictions and identify the parties to be restricted in writing to the Director of Medical Information.

*If you request that access be restricted to your PHI for services for which you have fully paid yourself out-of-pocket and not be made available to your insurance carrier, we must agree to your request.

- **Right of access to PHI.** You have the right to inspect and obtain a copy of your PHI upon your written request. Under very limited circumstances, we may deny access to your medical records. To request access to your medical record call Prime Fitness Physical Therapy, PC during business hours. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial letter within 30 days. There is an appeals process. We have the right to charge a reasonable fee for providing copies of your PHI.
- **Right to confidential communications.** You have the right to reasonable accommodation of a request to receive communication of PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent to an address other than your home. Please make your request in writing to Prime Fitness Physical Therapy, PC. We will not require an explanation of your reasons for the request, and will attempt to comply with reasonable requests, but you will be required to assume any costs associated with forwarding your PHI by alternate means.
- **Right to amend PHI.** You have the right to request that we amend your PHI. Your request must be made in writing to us. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial; Prime Fitness Physical Therapy, PC also has the right to submit a rebuttal statement. A record of any disagreement about amendment will become part of your medical record and may be included in subsequent disclosures of your PHI.
- **Right to accounting of disclosures.** Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. We will include all 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 of a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Right to a copy of our Notice of Privacy Practices and Policies.** We will ask you to sign a written acknowledgement of receipt of our Notice of Privacy Practices and Policies. We may periodically amend this Notice of Privacy Practices and Policies and you may obtain an updated Notice at any time.

8. **Complaint Procedure**

- **Within our Practice:** If you have a complaint about the denial of any of the specific rights listed in Section 7 above, about our Notice of Privacy Practices and Policies, or about our compliance with state and federal privacy law you may get more information about the complaint process by contacting Prime Fitness Physical Therapy, PC at (718)676-4134 or info@primefitnessphysicaltherapy.com. We will respond to your complaint in writing within the time - frames listed in Section 7 above or in any case within 30 days of the date of your complaint.
- **Outside our Practice:** If you believe that Prime Fitness Physical Therapy, PC is not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health & Human Services, Office of Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, DC 20201, calling (877)696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

9. **Marketing & Fundraising**

- **Fundraising Use:** Prime Fitness Physical Therapy, PC may contact you for fundraising efforts, but you can tell us not to contact you again.

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- **Marketing Use: Prime Fitness Physical Therapy, PC** shall obtain a patient authorization for use or disclosure of PHI for marketing purposes. If the marketing is expected to result in direct or indirect remuneration from a third party, the individual shall be notified that such remuneration is expected.

10. **Effective Date.** This Notice is effective as of 5/11/2019

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Prime Fitness Physical Therapy, PC N*otice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Prime Fitness Physical Therapy, PC may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Prime Fitness Physical Therapy, PC *Notice of Privacy Practices* by submitting a request in writing for a current copy of Prime Fitness Physical Therapy, PC *Notice of Privacy Practices*.

Printed Patient Name	Signed Patient Name	Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

Printed Patient Representative Name	Patient Representative Signature	Signature Date

Relationship to Patient

For Prime Fitness Physical Therapy, PC Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Prime Fitness Physical Therapy, PC made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign

☐ Patient or patient's personal representative unable to sign

☐ Other_____

Printed Employee Witness Name	Employee Witness Signature	Date