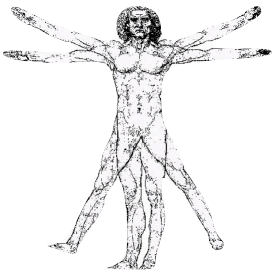


FARMINGTON VALLEY PHYSICAL THERAPY & SPORTS MEDICINE, P.C.

FEDERAL ID #06-1320020

112 South Main St
Unionville CT 06085
Telephone: (860) 673-0223

Fax: (860) 673-7605
Email: info@fvpt.com
Web: http://www.fvpt.com/

REGISTRATION FORM

NAME:_____ DATE:_____

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____

STREET ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE:_____

CELL PHONE: _____ EMAIL ADDRESS:_____

SEX: MALE_____ FEMALE _____ MARITAL STATUS: SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED_____

OCCUPATION: _____ STUDENT: FULL TIME _____ PART TIME_____

EMPLOYER:_____

EMPLOYER ADDRESS:_____

IF MINOR, NAME OF PARENT OR LEGAL GUARDIAN:_____

In case of emergency, please list someone that FVPT can contact. FVPT may have to discuss your personal health information.

EMERGENCY CONTACT NAME: _____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE:_____

NAME OF REFERRING PROVIDER: _____ DATE OF NEXT APPOINTMENT:_____

NAME OF PRIMARY CARE PROVIDER: _____ DATE OF NEXT APPOINTMENT:_____

NAME OF ATTORNEY (IF APPLICABLE): _____ ATTORNEY'S PHONE:_____

HOW DID YOU HEAR ABOUT US?_____

_____

WOULD YOU LIKE TO SIGN UP FOR A COMPLEMENTARY MEMBERSHIP TO SOMA MOVEMENT STUDIO FOR GROUP EXERCISE CLASSES? (IF YES, PLEASE INCLUDE YOUR EMAIL ADDRESS ABOVE SO WE CAN CREATE AN ACCOUNT FOR YOU)

YES_____ NO _____

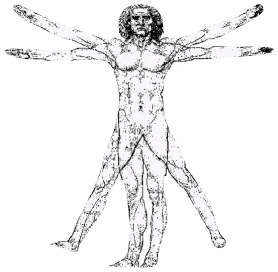
HOW AND WHAT DID YOU INJURE?_____

_____

AUTHORIZATION TO TREAT AND PAY BENEFITS TO FARMINGTON VALLEY PHYSICAL THERAPY & SPORTS MEDICINE P.C.:
I, the undersigned, do hereby authorize treatment of myself, or my dependent, at Farmington Valley Physical Therapy and Sports Medicine P.C. for the course of treatment as prescribed by my or my dependents's provider, or as directed by the physical therapist in the case of direct access, and direct payment to Farmington Valley Physical Therapy and Sports Medicine P.C. for their services. I further agree to be responsible for payment of services, including deductibles and copayments. I further authorize the payment of benefits, directly to Farmington Valley Physical Therapy and Sports Medicine P.C. In the event of non-payment, I agree to be responsible for reasonable collection fees, if necessary. I further authorize Farmington Valley Physical Therapy and Sports Medicine, P.C. to release all medical information pertaining to my or my dependent's injuries to the insurance carrier and attorney as I have provided them.

Signed (Legal Guardian if applicable): _____ Date:_____

Witness (if applicable): _____ Date:_____



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MEDICAL SCREENING QUESTIONAIRE

NAME:_____OCCUPATION: _____

LEISURE ACTIVITIES: _____

ALLERGIES: List any medication(s) you are allergic to: Are you latex sensitive? Yes No List any other allergies we should know about?

Please check (check) any of the following whose care you're under

□ Medical doctor (MD) □ Osteopath □ Other Physical Therapist	□ Chiropractor □ Other:

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

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

YES NO Cancer. If YES, describe what kind: YES NO Are you pregnant? YES NO Rheumatoid arthritis YES NO Other arthritic conditions YES NO Heart Problems YES NO Depression YES NO High blood pressure YES NO Hepatitis YES NO Circulation problems YES NO Tuberculosis	YES NO Asthma YES NO Stroke YES NO Emphysema/Bronchitis YES NO Kidney disease YES NO Anemia YES NO Thyroid problems YES NO Epilepsy YES NO Diabetes YES NO Osteoporosis/Osteopenia YES NO Multiple sclerosis YES NO Other:

YES NO	During the past month have you been feeling down, depressed or hopeless?
YES NO	During the past month have you been bothered by having little interest or pleasure in doing things?
YES NO	Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?
YES NO	Do you desire the services of a social worker (assistance with financial, personal/social, medical or vocational issues) due to your illness or injury?

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Has anyone in your IMMEDIATE FAMILY (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes YES NO Cancer YES NO Tuberculosis YES NO Arthritis YES NO Heart disease YES NO Anemia YES NO High blood pressure	YES NO Headaches YES NO Stroke YES NO Epilepsy YES NO Kidney disease OTHER:

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES NO Aspirin YES NO Antihistamines YES NO Tylenol YES NO Antacid YES NO Advil/Motrin/Ibuprofen YES NO Vitamins/mineral supplements	YES NO Laxatives YES NO Herbs YES NO Decongestants YES NO Other:

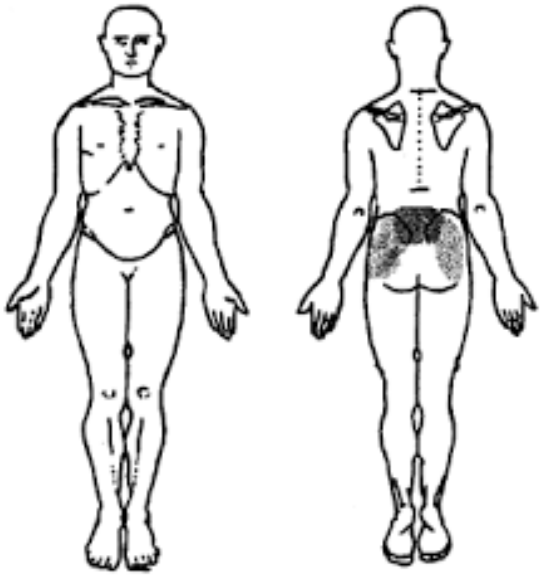
Have you recently noted:

YES NO Weight loss/gain YES NO weakness YES NO fever/chills/sweats	YES NO fatigue YES NO numbness or tingling YES NO nausea/vomiting

On a scale from 0 to 10- rate your pain:

Best: Worst: Current:

Please mark on the diagram to the right where your pain is:



Describe the type of pain you are experiencing:

□ Ache □ Burning □ Dull □ Pulsing
□ Sharp □ Stabbing □ Steady □ Throbbing
□ Shooting □ Other:

When did you first experience the pain?

What activities alleviate your pain?

What activities aggravate your pain?

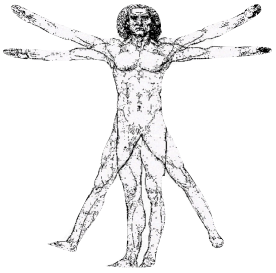
Has your condition been getting better or worse?

YES NO Are you currently participating in a regular exercise routine?

If YES, What are you doing?

Signature: _____ Date:_____

Print Name:_____



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NAME:_____TODAY'S DATE:_____

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because, it can make the difference between whether you succeed in your treatment or not. Usually your referring provider and/or your therapist have prescribed a set frequency of treatment. Attending these visits is your most important job. Other than that, all you need to do is follow you therapist's instructions and we will be able to help you achieve your goals in treatment.

We require **24 hour notice** in the event of cancellation. When you call in, it is your responsibility to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work, since some forms of treatment do not work well if given two sequential days).

There is a **$15 charge for cancellation without proper notice**. This charge will not be covered by insurance, and will have to be paid by you personally.

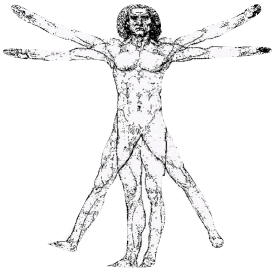
For Workers Compensation and Personal Injury Patients, documentation of any missed appointments is forwarded to your case manager and Primary Care Providers and this could jeopardize your claims.

You may need to see a therapist other than one who normally treats you if you do rearrange your appointments. All of our therapists are experienced professionals, and they will study your health record, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

Please understand that your pain will probably increase and decrease as the course of treatment progresses before it is finally resolved. Either condition can seem to be a reason not to come in: a) you are feeling worse and think the treatment is not working or b) you are feeling much better. Neither of these cases are legitimate reasons to discontinue or postpone physical therapy. If you are in pain, you should attend your physical therapy appointment so your pain can be treated. If you are feeling well, this is an opportunity for the therapist work with you to remedy the cause of your injury and teach you how to avoid future injuries. When you do not attend your schedule physical therapy appointment, three people are hurt. You are put at a disadvantage as you do not get the treatment you need as prescribed by your physician and/or physical therapist, the physical therapist who now has a space in their schedule since that time was reserved for you, and finally, another patient who could have been scheduled for the treatment time slot if you had given proper notice.

Please appreciation your understanding in this regard. We are looking forward to working with you.

Patient (Legal Guardian's) Signature:_____Date:_____



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PRIVACY PRACTICES

INTRODUCTION

Federal and state laws require that we maintain the privacy of your health information. The Law also requires that we make available this notice about our privacy practices, our legal duties and your rights concerning your health information. This policy took effect April 14, 2003, and will remain in effect until we replace it with a modified notice. This notice describes how the protected health information may be used and disclosed and how you can get access to this information. We reserve the right to change our privacy policy and the terms of this notice at any time. We will abide by the terms of this notice as long as it is in effect. When we make a significant change in our privacy practices, the new form will be available. You can obtain a copy of the form at any time during business hours by contacting us at the address below.

YOUR HEALTH INFORMATION AND HOW IT IS USED AND DISCLOSED

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: Your health information may be disclosed to other healthcare professionals involved in your treatment. This includes the referring physician and any other healthcare individual involved in your medical care.
Payment: Your health information may be disclosed to insurance carriers, legal representatives, or other authorized individuals to obtain payment for services we provided to you.
Company Operations: Your health information may be disclosed to other individuals within Farmington Valley Physical Therapy in connection with our operations. These operations include but are not limited to quality assessment, evaluation of staff performance, and accreditation.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization for any reason except those described in this Privacy Practice statement.
Family and Friends: With your consent; your health information may be disclosed to a family member, friend, acquaintance, or other person in order to help you with your treatment or payment for your healthcare.
Legally Mandated Disclosure: Your health information may be disclosed to those institutions that require reporting as required by law. In addition, we may provide information about you when required by a court of law.
Appointment Reminders: We may use your health information to provide you with appointment reminders.
Access to Medical Information: You may obtain a copy of the medical information we have concerning you, with limited exceptions. In order to obtain copies of your health information, you must make a request in writing to the address below. You will be charged a reasonable cost for research time, staff cost, materials, and postage. The request will be fulfilled within 60 days.
Disclosure Accounting: You may request a list of instances where your healthcare information was disclosed other than for treatment, payment, company operations for the last 6 years, but not before April 14, 2003. In order to obtain copies of your health information, you must make a request in writing to the address below. You may be charged a reasonable cost for research time, staff cost, materials, and postage if the request is made more than once in a 12 month period.
Restriction on Disclosure of Information: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Change of Information: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be changed.) We may deny your request under certain circumstances.

QUESTIONS

If you want more information, are concerned about your rights, disagree with a decision made by us, or wish to amend the disclosure of your information, please contact us. You may also write to the U.S. Department of Health and Human Services. We will provide you with the address upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Farmington Valley Physical Therapy and Sports Medicine, PC
Office Manager
112 South Main Street
Unionville, CT 06085

Patient (Legal Guardian's) Signature:_____Date:_____

SOMA Movement Studio CANCELLATION / NO-SHOW POLICY

We strive to provide not simply good, but absolutely the best care to our clients. We schedule our clients according to care plans that optimize their wellness outcomes. Making your appointment as scheduled is very important, not just for us, but for you. We are convinced that if you make your wellness a life priority, you will achieve not only a higher level of function, but a greater degree of happiness.

We have the most highly trained and experienced clinicians in the region. You are working with the best. Their services and time are in high demand. We attempt to schedule all new clients within 24-48 hours of their initial request for service. Thus, the appointment time is a valuable commodity for both you and us.

If it is necessary to cancel a scheduled Pilates Session, please call the office at (860) 470-MOVE (6683) at least 24 hours in advance. If you call within 24 hours or less from the scheduled time or you do not show for your Pilates session, you will be charged for that visit. The missed session will be deducted from any package you have on account at the package price. If you pay individually, the single price for the missed session will be added to the payment of your next session.

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy is in the best interest of accommodating all of our clients who are dedicated to improving their wellbeing. Thank you for your consideration. By signing below, I understand and accept the above cancellation / no-show policy. I have read the above cancellation policy and agree to pay for any appointments cancelled less than 24 hours in advance.

Signature: _____ Date:_____

Print Name:_____

SOMA Movement Studio at
Farmington Valley Physical Therapy
112 South Main St
Unionville CT 06085
Clinic Ph: (860) 673-0223
Studio Ph: (860) 470-6683

SOMA Movement Studio

WAIVER AND RELEASE FROM LIABILITY AND INDEMNITY AGREEMENT

I, the undersigned, hereby request permission to use the facilities owned and operated by Farmington Valley Physical Therapy and Soma Movement Studio at 112 South Main St, Unionville, CT 06085. I know the risks and dangers in using said facilities and all equipment currently on the premises or on the premises in the future and in participating in such activities, and that unanticipated and unexpected dangers may arise during the use of said facilities and equipment and during the participation in said activities, and I ASSUME ALL RISKS OF INJURY TO MY PERSON, INCLUDING DEATH, AND TO MY PROPERTY that may be sustained in connection with the stated and associated activities.

In consideration for being permitted to use the facilities and equipment of Farmington Valley Physical Therapy and Soma Movement Studio, I agree, in addition to paying for the services rendered, to release Farmington Valley Physical Therapy and Soma Movement Studio, its instructors, operators, owners, servants, agents, officials, officers and sponsors from all claims from liability, demands, actions, and causes of actions of any sort made by myself, my heirs, administrators, executors, guardians, and/or assigns arising out of injury to my person or out of my death or injury to my property, whether caused by the negligence of Farmington Valley Physical Therapy and Soma Movement Studio, its instructors, operators, owners, servants, agents, officials, officers or sponsors while I am using its facilities or equipment or participating in other activities sponsored by Farmington Valley Physical Therapy and Soma Movement Studio on or off its premises.

I also agree to indemnify and hold harmless Farmington Valley Physical Therapy and Soma Movement Studio, its instructors, operators, owners, servants, agents, officers, officials, and sponsors, for any loss, liability, damage or cost they may incur due to my presence on the premises of Farmington Valley Physical Therapy and Soma Movement Studio whether caused by the negligence of Farmington Valley Physical Therapy and Soma Movement Studio, its instructors, operators, owners, servants, agents, officers, officials or sponsors or otherwise.

I represent and certify that my true age is years and I am over the age of eighteen (18) years.

(OR)

I represent and certify that my child is years of age and I, as parent or legal guardian, consent to and authorize my child's participation in the above stated activities and I have full knowledge thereof and, as parent or legal guardian, knowingly and voluntarily executed this Waiver and Release form Liability and Indemnity Agreement.

I certify that my attendance and participation in the stated activities are voluntary.

IN WITNESS WHEREOF, I have executed this WAIVER AND RELEASE FROM LIABILITY AND INDEMNITY AGREEMENT ON:

Signature: _____ Date:_____

Print Name:_____

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Studio Ph: (860) 470-6683