# Patient Express

PRIME Therapy
& Pain Center

Today's Date:

3421 Arlington Avenue, Suite 105, Riverside, CA 92506
Phone: (800) 758-0097 Fax: (951) 934-0555

## 1. Personal Info

Please Fill-Out Entire Form Completely & Legibly

Last Name_____ First Name _____ Age:_____ Sex: ❒ Male ❒Female

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

Home Phone: (_____)_____ Cell Phone: (_____)_____ Email Address:_____

Occupation:_____ Employer Name: _____ Phone: (_____)_____

Employment Status: ❒ Currently Employed ❒ Retired ❒ Disabled (___ Total or ____Temporary) ❒ Student (___ Part Time ____Full Time)

Emergency Contact: _____ Phone: (_____)_____Minor:_____

Social Security #:_____/_____/_____ Date of Birth:_____/_____/_____ ❒ Single ❒Married

Signature (If Patient Minor, of Parent/Guardian: _____ Today's Date:_____/_____/_____

## 2. My Condition Info

** ALL INFO REQUIRED**

**My Injury/ailment is related to . . .**

❒AUTO/PERSONAL INJURY: Date of Accident ___/___/_____

❒WORK INJURY: Complete all information below.

Date of Injury _____/_____/_____

Your company HR person Name: _____
Insurance adjustor name: _____
Insurance adjustor Phone #: _____

❒ NO INJURY: What do you think my have caused it?

**I have already had . . .**

❒ SURGERY: What type? _____ Date: ___/___/____

❒ PHYSICAL THERAPY BEFORE: where: ____ Date: ___/___/____

❒ HOME HEALTH: Are you still receiving it? ___ YES ___ NO

❒ OTHER CARE: What Type: _____

## 3. Payment Info

hh

**I am paying TODAY by….**
(Check one box only"

❒ **INSURANCE** and would like you to:
____Have you deal directly with them. I will assign my benefits to you by completing the "**Assignment of Benefits Form**" (Fees may apply in some cases).The following information is required prior to 1st visit.

My coinsurance/copay is $_____ Allowed # of visits _____
My deductible is $_____ Deductible met ? Y/N
Prior Authorization needed? Y/N

❒ **WORKERS COMP:**
You must have all info under "My Condition…"

❒ **CASH, CHECK, CREDIT** and would like a:
____Up to 20% discount by paying at the time of service. *Ask for Details
____Payment plan and apply for "Financial Hardship"

❒ **I HAVE AN ATTORNEY** and would like a:
____Up to 20% discount by paying up front, I'll get reimbursed after my case is settled.
____ Wait until my case settles before paying, I Will complete the "Attorney Lien" form. (Fees may apply)

## 4. Referral Info

**How did you hear about**

❒ Friend or Family: ❒: Brochure (Details)
❒ Internet
below)
❒ Advertisement:
_____

❒Physician/Dentist/Chiropractor/Nurse: (Give details

Referring Physician's Name:

**PRE-EXAM FORM:** In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME:_____ AGE:_____ GENDER: ❑ Female ❑ Male

OCCUPATION:_____ ARE YOU WORKING NOW? ❑ Yes ❑ No

| | | | |
|---|---|---|---|
| 1. | Where is your pain/problem? | | |
| 2. | What caused your pain/problem? | | |
| 3. | Approximately when did it start? | | |
| 4. | List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again: | | |
| 5. | Have you ever had this same (or similar) pain/problem before? | ❑ Yes (If yes, when and describe?)<br>❑ No | |
| 6. | In your understanding, what do you think will make it better? | | |
| 7. | How optimistic are you that you'll get better? (circle one) | Not at all……Mildly optimistic……Fairly……Very optimistic……..Extremely | |
| 8. | What are some potential obstacles to you getting better? | | |
| 9. | Over the next 30-days, how many hours per week will you commit to getting better? | | |
| 10. | What are you expecting from therapy? | | |
| 11. | On the scale, circle your worst pain level in the past couple of days: | *Mild* *Moderate* *Severe*<br>0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10 | |
| 12. | List any medications you are taking: | | |
| 13. | List all past surgeries with dates: | | |
| 14. | List all medical conditions you have (or were told you have): | | |

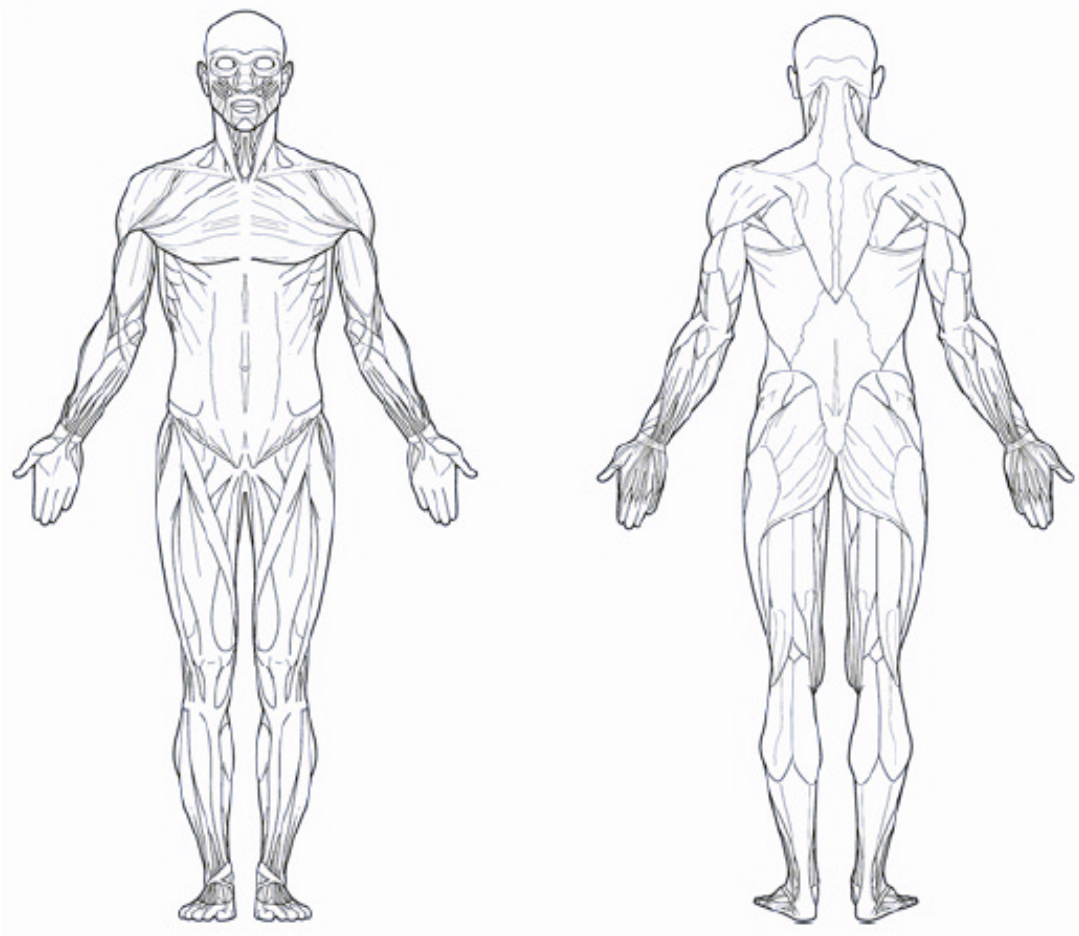
Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian):_____ Date: _____

**Functional Outcome Measures**

Please mark the areas where you feel your symptoms:



**1.** How have your symptoms changed? □getting better □about the same □getting worse

**2.** What makes your symptom better? _____

**3**.What makes your symptom worse? _____

**4. Patient Specific Functional Scale:** Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem:

**Scoring Scheme:**
0 1 2 3 4 5 6 7 8 9 10
("0" Means "unable to perform activity") ("10" Means "able to fully perform activity")

| Activity | Score |
|---|---|
| a. | |
| b. | |
| c. | |
| Overall average level of functions you can perform ---------- | |

# 24 Hour Cancellation & "No-Show" Fee Policy

It has been proven that consistent treatment attendance provides the greatest opportunity for faster improvement & recovery. Each time a Patient misses an appointment without providing proper notice, another Patient is prevented from receiving timely care in that appointment slot. Therefore, PRIME Therapy & Pain Center reserves the right to charge a fee of $50 for all missed appointments (No-Shows) which lack a compelling reason and are not cancelled with a 24-hour advance notice.

"No-Show" fees will be billed to the Patient. This fee is not covered by Insurance and must be paid prior to your next appointment. Multiple "No-Shows" in any 12-month period may result in termination from our practice.

We do understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Shows/Late Cancellations policy will be determined by the Director of Rehabilitation.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our Patients.

PRIME Therapy & Pain Center reserves the right to modify the 24 hour advance cancellation notice and amount of No-Show/Late Cancellation charge, as deemed necessary.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____

Patient Name

_____ _____

Patient Signature Date

**RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AND PARENTAL CONSENT AGREEMENT**
**("AGREEMENT")**

IN CONSIDERATION of being permitted to participate in the PHYSICAL THERAPY PROGRAM ("Activity") I, for myself for family, friends, representatives, assigns, heirs, and next of kin:

1. ACKNOWLEDGE, agree, and represent that I understand the nature of PHYSICAL THERAPY Activities and that I am qualified, in good health, and in proper physical condition to participate in such Activity. I further agree and warrant that if at any time I believe conditions to be unsafe, I will immediately discontinue further participation in the Activity.
2. FULLY UNDERSTAND THAT: PHYSICAL THERAPY ACTIVITIES INVOLVE RISKS AND DANGERS OF SERIOUS BODILY INJURY, INCLUDING PERMANENT DISABILITY, PARALYSIS, AND DEATH ("RISKS"); (b) these Risks and dangers may be caused by my own actions or inaction's, the actions or inaction's of others participating in the Activity, the condition in which the Activity takes place, or THE NEGLIGENCE OF THE "RELEASEES" NAMED BELOW; (c) there may be OTHER RISK AND SOCIAL AND ECONOMIC LOSSES either not known to me or not readily foreseeable at this time; and I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES I incur as a result of my participation or that of the minor in the Activity.
3. HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE PRIME Therapy and Pain Center OR their respective administrators, directors, agents, officers, members, volunteers, and employees, other participants, any sponsors, advertisers, and, if applicable, owner and lessors of premises on which the Activity takes place, (each considered one of the "RELEASEES" herein) FROM ALL LIABILITY, CLAIMS, DEMANDS, LOSSES, OR DAMAGES ON MY ACCOUNT CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF THE "RELEASEES" OR OTHERWISE, INCLUDING NEGLIGENT RESCUE OPERATIONS AND I FURTHER AGREE that if, despite this RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT I, or anyone on my behalf, makes a claim against any of the Releasees, I WILL INDEMNIFY, SAVE, AND HOLD HARMLESS EACH OF THE RELEASEES from any litigation expenses, attorney fees, loss, liability, damage, or cost which may incur as the result of such claim.

I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

**Name of PATIENT/PARTICIPANT** (Please Print): _____

Street Address: _____ City: _____ State: ____ Zip: _____

Phone: _____

PATIENT/PARTICIPANT Signature (If Minor, Please See Below):_____ Date: _____

**MINOR RELEASE**

AND I, THE MINOR'S PARENT AND/OR LEGAL GUARDIAN, UNDERSTAND THE NATURE OF PHYSICAL THERAPY ACTIVITIES AND THE MINOR'S EXPERIENCE AND CAPABILITIES AND BELIEVE THE MINOR TO BE QUALIFIED, IN GOOD HEALTH, AND IN PROPER PHYSICAL CONDITION TO PARTICIPATE IN SUCH ACTIVITY. I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS EACH OF THE RELEASEE'S FROM ALL LIABILITY CLAIMS, DEMANDS, LOSSES, OR DAMAGES ON THE MINOR'S ACCOUNT CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF THE "RELEASEES" OR OTHERWISE, INCLUDING NEGLIGENT RESCUE OPERATION AND FURTHER AGREE THAT IF, DESPITE THIS RELEASE, I, THE MINOR, OR ANYONE ON THE MINOR'S BEHALF MAKES A CLAIM AGAINST ANY OF THE RELEASEES NAMED ABOVE, I WILL INDEMNIFY, SAVE, AND HOLD HARMLESS EACH OF THE RELEASEES FROM ANY LITIGATION EXPENSES, ATTORNEY FEES, LOSS LIABILITY, DAMAGE, OR COST ANY MAY INCUR AS THE RESULT OF ANY SUCH CLAIM.

**Name of PARETN/GUARDIAN** (Please Print): _____

Street Address: _____ City: _____ State: ____ Zip: _____

Phone: _____

**PARENT/GUARDIAN** (only if participant is under the age of 18):

PARENT/GUARDIAN Signature: _____ Date: _____

# Informed Consent and Policies Agreement

**Medical Necessity**

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

If the above criteria are not met, you are welcome to participate in our elective services such as 830laser, massage, myofascial treatments, fitness/exercise training, Pulsetron, Posture Program, etc. payable out-of-pocket by cash, check or credit card.

**Authorization for Release of Records**

**Assignment of Benefits** (for insurance patients) **Please refer to the Assignment of Benefits form.**

**Results**

The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

**Insurance Patients**

It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

**Medicare Patients**

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

**Minors and Parents**

If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

**Informed Consent**

By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries. Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

**Patient Declaration**

The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| Patient Signature | Date | Patient's Representative Signature | Date |
| _____ | _____ | _____ | _____ |
| Witness Signature | Date | Relationship to Patient | Date |

## Important Company Policies

### Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a “Financial Hardship Form” which may be filled out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill.

### Important Notice from the Federal Government:

“It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments. even if your doctor allows it. Unless you complete a “Financial Hardship” form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan, even if your doctor allows it. You may both be charged with breaking the law. This includes services deemed as “professional courtesy” and TWIP’s – take what insurance pays”. Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A (a)(5) of the Health Insurance Portability and Accountability Act of 1996 (section 231(h) of HIPAA). Exceptional cases do apply.

Please see contact info for more information:
Office of Inspector General,
Department of Health and Human Services.
Phone: 202-619-1343, by fax 202-260-8512,
Email:paffairs@oig.hhs.gov,
Mail:
Office of Inspector General,
Office of Public Affairs,
Dept. of Health and Human Services,
Room 5541 Cohen Building 333 Independence Ave,
S.W., Washington, D.C. 20201,

Joel Schaer,
Office of Counsel to the Inspector General
Phone: 202-619-0089.”

***We look forward to building a relationship with you that will last a lifetime!***

***Signature*** _____ ***Date*** _____

# Assignment of Benefits to PRIME Therapy & Pain Center

Patient Name:_____

Insurance Policy #:_____

Insured Name:_____Insured Date of Birth_____

Your relationship to the Insured: ❑ Parent ❑ Spouse ❑ Other:_____

Claim #_____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

**PRIME Therapy & Pain Center**
**3421 Arlington Ave. Suite 105**
**Riverside, CA 92507**
**951-684-2865**

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the Payments to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

## This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize PRIME Therapy & Pain Center to deposit Payments made in my name.
- ❑ I authorize PRIME Therapy & Pain Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

**A. Notifier:**

**B. Patient Name:** **C. Identification Number:**

# Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE:** If Medicare doesn't pay for D._____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| 1. Performance program<br>2. Maintenance (Transition) Program<br>3. Personal Training, Fitness, Weight Loss<br>4. Recovery Program<br>5. Membership Program<br>6. Laser<br>7. ShockWave<br>8. Cocoon Fitness Pod | Non-Medical Necessity | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D._____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.**

PRIME Therapy &
Pain Center

chattanooga®

# Informed Consent for
# Focus Shockwave Wave Therapy

Focus Shockwave therapy (F-SW), also known as extracorporeal shockwave therapy (ESWT), is a procedure regarded as one of the most cost effective and safest of conservative management approaches to musculoskeletal disorders such as plantar fasciitis. Our device is FDA approved for treatment of such conditions, although we are not limited by the FDA.

There are minimal known side effects of F-SW. It is recommended, however, that this form of treatment not be used over and around the uterus during pregnancy; where there is active ongoing hemorrhaging/bleeding tendencies; when there is any indication or diagnosis of blood clots; over and around the thyroid gland; cancer (tumors or cancerous areas); over the cardiac region and large nerves, directly over spinal column or head; where analgesia/pain relief may mask progressive pathology; over an area of an electromagnetic implanted device; in a patient taking medication that may thin the blood (eg Warafin); over open wounds, skin irritation or swollen areas; over the growth plates in children.

I hereby consent to the performance of Focus Shockwave Therapy on me by PRIME Therapy & Pain Center. I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below, I agree to the procedures. I understand that there are no guarantees with any type of treatment as it is dependent upon each individual's ability to heal.

I intend this consent form to cover the entire course of care for my present condition(s) and for any future conditions(s) for which I seek care. I am financially responsible for all services.

_____ _____

Signature (client/parent/guardian) Date

**Please ask questions if you do not understand this document or the treatment that is about to be performed.*

3421 Arlington Ave. Suite 105, Riverside, CA 92506 Phone: (951) 684-2865 Fax: (951) 934-0555

PRIME Therapy &
Pain Center

lightforce®
therapy lasers

# Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. LightForce therapeutic lasers emit infrared light energy into tissue to provide topical heating for the purpose of elevating tissue temperature for temporary relief of minor muscle and joint pain, muscle spasm, pain and stiffness associated with arthritis and promoting relaxation of the muscle tissue and to temporarily increase local blood circulation. Laser therapy utilizes visible and invisible laser radiation; therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment. You may see immediate results after the first treatment, or depending on the severity of your condition, you may require several treatments before beginning to feel results.

Increased soreness may occur after your first laser session. This may be due to changes in circulation to the involved tissues and/ or the impact on different sensory nerves. This is a normal phenomena in the healing process.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

☐ I understand the above and consent to treatment.
☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

_____ _____
Patient Signature Date

_____
Print Patient Name (Please Print)

_____ _____
Physician Signature Date Date

3421 Arlington Ave. Suite 105, Riverside, CA 92506 Phone: (951) 684-2865 Fax: (951) 934-0555

Prime Therapy & Pain Center

# WELLNESS POD CONSENT FORM

This Release and Waiver is entered into by and between PRIME Therapy & Pain Center ("Provider") and the undersigned client ("Client"), effective on the date written below. In consideration of Provider permitting Client to receive Cocoon Red Wellness POD® sessions ("CRW session") Client agrees as follows:

**(1) Representation of Ability to Participate:**
Client represents that he or she is of legal age and in satisfactory physical condition and has no medical condition that would prevent Client from receiving a CRW session. Client affirms he or she is properly hydrated and he or she has had the opportunity to inspect the facility, learn about the CRW session, and ask any questions he or she may have regarding the CRW session. Client affirms he or she has had the opportunity to consult his or her physician about any unique needs or restrictions Client may have prior to receiving a CRW session. In the event of an accident, and at Client's sole expense, Client hereby authorizes medical transportation to a medical facility or hospital.

**(2) Acknowledgement and Assumption of Risks:**
Client acknowledges he or she is aware a CRW session involves dry heat sauna combined with infrared heat and may require physical exertion that may be strenuous and may cause physical injury, and Client acknowledges that he or she is fully aware of the risks and hazards involved. Client fully accepts and assumes all such risks and all responsibility for losses, costs, and damages that may result from a CRW session.

**(3) Release.**
Client hereby releases, acquits, covenants not to sue and therefore discharges Provider, its owners, officers, administrators, employees, instructors, and/or agents, as well the owners, distributors, manufacturers, wholesalers, and any other entity affiliated with CRW (collectively "Released Parties") of and from any and all actions, and knowingly, voluntarily, and expressly waives any claim Client may have against the Released Parties for any injuries or damages (known or unknown), property damage or loss of any kind, including death, whether such injury, damage, loss, or death was caused by the alleged negligence of Provider, another client, or any other person or cause, which Client may sustain as a result of receiving a CRW session.

**(4) Indemnification:**
Client further voluntarily defends, indemnifies, and holds harmless the Released Parties from any and all liabilities or claims made as a result of or relating to Client receiving a CRW session, including attorney's fees, for any accident, injury, illness, death, loss, damage to person or property, or other consequences suffered by Client or any other person arising or resulting directly or indirectly from Client receiving a CRW session, whether such injury, death, loss, or damage was caused by the alleged negligence of Provider, another client, or any other person or cause.

**(5) Severability:**
Client further expressly agrees that the foregoing Release and Waiver is intended to be as broad and inclusive as is permitted by the laws of the United States, and the state in which it is signed, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. Client affirms he or she has been fully informed and understands the use of CRW and has prepared for CRW session as indicated and accepts personal responsibility for his or her session. Client is aware that the results achieved by this CRW session may vary from person to person, and Client acknowledges that no promises or guarantees have been made to Client as to the results of this session. Client understands Provider does not diagnose conditions or illnesses.

This Release and Waiver is governed by the laws of the State of California, and exclusive jurisdiction shall be in Riverside County. This Release and Waiver shall be binding on the Client's assignees, heirs, next of kin, executors, and personal representatives. CLIENT FURTHER AFFIRMS THAT NONE OF THE CONTRAINDICATIONS LISTED ON THE REVERSE OF THIS FORM THAT PREVENT PARTICIPATION IN RECEIVING A COCOON RED WELLNESS POD® SESSION APPLY TO CLIENT. CLIENT REPRESENTS THAT HE OR SHE HAS CAREFULLY READ AND UNDERSTOOD THE CONTENTS OF THIS RELEASE AND WAIVER. CLIENT IS EXECUTING THIS FORM VOLUNTARILY AND WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE.

_____ _____

Client Signature Date

_____

Client Full Name

3421 Arlington Ave. Ste. 105, Riverside, CA 92506 **Phone**: (800) 758-0097 **Fax**: (951) 934-0555

**Prime Therapy & Pain Center**

## CONTRA-INDICATIONS FOR COCOON POD
## (PLEASE READ CAREFULLY AND CIRCLE ALL THAT APPLY)

| | |
|---|---|
| Cardiac Condition | Y/N |
| Implanted Pacemaker | Y/N |
| Pregnancy | Y/N |
| Open Wounds | Y/N |
| Several General Infections | Y/N |
| Lactation (Breast Feeding) | Y/N |
| Low Blood Pressure | Y/N |

| | |
|---|---|
| Hemophilia | Y/N |
| Infectious Skin Disease | Y/N |
| Multiple Sclerosis | Y/N |
| Fever | Y/N |
| Active Cancer | Y/N |
| Epilepsy | Y/N |

Consult your doctor before receiving a Cocoon Pod session if you have received care for any of the above listed conditions in the Contra-Indications area. You should **NOT** receive a Cocoon Pod session if you suffer from any of the conditions described above or any other condition where the use of an infrared heat session is contraindicated or if you are under the legal age in your jurisdiction.

**IF YOU HAVE A HISTORY OF ANY OTHER MEDICAL CONDITION, OR YOU ARE TAKING PRESCRIPTION OR OVER THE COUNTER DRUGS, YOU SHOULD CONSULT YOUR PHYSICIAN BEFORE USING THE COCOON POD.**

Before and after a Cocoon Pod session, it is imperative to stay hydrated by drinking plenty of fluids. If any of the Contra-Indications apply to you, or you have a history of any other medical condition, or you are taking prescription or over the counter drugs, the section below must be signed by your physician prior to receiving a Cocoon Pod session

_____ _____
Doctor's Name Phone Number

_____
Doctor's Approval

_____ _____
Client Signature Date

3421 Arlington Ave. Ste. 105, Riverside, CA 92506 **Phone**: (800) 758-0097 **Fax**: (951) 934-0555

# Statement of Privacy Notice

*Effective August 1, 2010*

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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by us.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at **(800) 758-0097**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at **(800) 758-0097**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date