



Dear Dr. _____,

Your patient _____ wishes to take part in an exercise program and/or fitness assessment at our clinic. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program that will increase in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of the body composition, flexibility, and muscular strength endurance. As required by Medically-Based Fitness, all participants need a medical clearance from their Primary Care Physician concerning any medical history or treatments that may be contraindicated or high risk, to cardiovascular and strength training activities.

I consent to and authorize _____ to release to Medically-Based Fitness' Exercise Physiology Staff, health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Signature of participant

Printed name of participant

Date

I am requesting your medical opinion regarding my participation in said program. **Please assist by checking the appropriate boxes below and, where necessary, supplying relevant medical history information to Medically-Based Fitness.**

Participant has medical clearance to participate in an exercise program with the following medical history and/or considerations:

- HTN
- CAD
- COPD o O₂ _____L/min during exercise
- Angina
- Pacemaker
- Cardiac Arrhythmia
- Diabetes
- CHF
- Osteoporosis
- Arthritis
- Balance Deficits
- Sight Deficits
- Dyspnea
- AA
- Stroke (CVA/TIA)
- Seizures/Epilepsy
- Back or Neck problems/Joint Pain
- Communicable Diseases
- Peripheral Neuropathy
- Other:

Because of medical issues I would like to speak directly to the Therapist or Medical Director prior to approval. I can be reached at: _____

Signature of Physician Date

Informed Consent and Release of Liability for Medically-Based Fitness

Explanation of Exercise Program

You will be participating in a Supervised Exercise Program. The level of the exercises which you will undertake will be based on your medical history information provided by you during an evaluation session, relevant medical information and clearance provided by your primary care physician, your cardiovascular response to exercise, and other clinical information. You will be given clear instructions regarding the amount and kind of regular exercise you should do. Your exercise sessions may be adjusted by the program staff, and at your physician's discretion, depending upon your progress.

Monitoring

We will monitor your pulse rate, blood pressure, and oxygen saturation before and during your exercise sessions. You agree to report to the program staff any unusual, new or worsened symptoms associated with your exercise program. These include but are not limited to unusual shortness of breath, pain, pressure, tightness, heaviness in the chest, neck, jaw, back and/or arms, unusual fatigue with exercise, unusually fast, slow, or irregular heart rate, faintness or dizziness.

Attendant Risks and Discomfort

There exists the possibility of certain changes occurring during exercise sessions. These include abnormal blood pressure, fainting, irregular, fast, or slow heart rhythm, and in rare instances, heart attack, stroke, or death. Every effort will be made to minimize those risks by provision of appropriate supervision during exercise. In the event of emergency trained personnel will be called upon to deal with unusual situations that may arise. In consideration of being allowed to participate in the Supervised Exercise Program at Medically Based Fitness, I hereby waive, release, and forever discharge Medically Based Fitness and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities of liability for the injuries or damage resulting from my participation in the Supervised Exercise Program at Medically Based Fitness.

Benefits to Be Expected

Participation in the Supervised Exercise Program may help you to participate in activities of daily living. No assurance can be given that the program will increase your exercise tolerance, although considerable evidence indicates improvement is usually achieved.

Responsibility of the Participant

To promote your safety and gain benefit, you must give priority to regular attendance and adherence to the prescribed intensity, duration, frequency, progression and type of activity.

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To achieve the best care:

DO NOT

Withhold any information pertinent to symptoms from any staff member.

Exceed your target heart rate.

Exercise when you do not feel well.

Exercise within 2 hours of using tobacco products or alcohol.

Use extremely hot water during showering after exercise (avoid sauna, steam bath, and extreme temperatures).

DO

Report any unusual symptoms that you experience before, during, or after exercise. (You may help assure the safety and well-being of others in the program if you would also report any unusual symptoms you notice in others.)

Follow, without exception, all recommendations made by the staff concerning limits on any exercise, weight-control, or health related activities which you may be encouraged to do and document by recordings.

Use of Medical Records

The information that is obtained while you are a participant in the Supervised Exercise Program at Medically Based Fitness will be treated as privileged and confidential. It is not to be released or revealed to any person except your primary care physician without your written consent. The information obtained, however, may be used for statistical analysis or scientific purposes with your right to privacy retained.

Inquires

Any questions about the Medically Based Fitness Supervised Exercise Program, the correct use of equipment, and exercise activity are welcome. If you have any doubts or questions, please ask the staff for further explanation.

**Informed Consent and Release of Liability
for Medically-Based Fitness**

Freedom of Consent

I agree to voluntarily participate in the Supervised Exercise Program at Medically Based Fitness. I understand that I am free to deny any consent if I so desire, both now, and at any point in the program.

I acknowledge that I have read this form in its entirety or it has been read to me, and I understand my responsibility in the Supervised Exercise Program in which I will be engaged. I accept the risks, rules and regulations set forth. Knowing these, and having had an opportunity to ask questions which have been answered to my satisfaction, I consent to participate in the Medically Based Fitness Wellness Supervised Exercise Program.

Date

Signature of Participant

Name Printed

Date

Signature of Authorized Delegate

Name Printed

NOTICE OF PRIVACY PRACTICES

ARBOR MEDICAL SERVICES, P.C. ("ARBOR"), ALPHA REHABILITATION ("ALPHA") AND MEDICALLY-BASED FITNESS ("MBF")

Effective Date: April 14, 2003

Version: September 1st, 2011

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.

WHO WILL FOLLOW THIS NOTICE?

- HEALTH CARE PRACTITIONERS WHO TREAT YOU AT ANY OF THE ARBOR, ALPHA AND MBF FACILITIES, AND EMPLOYEES, VOLUNTEERS, TRAINEES, INTERNS AND MEMBERS OF OUR STAFF
- ALL DEPARTMENTS AND OPERATING UNITS OF OUR COLORADO PROVIDER NETWORK

OUR DUTIES REGARDING MEDICAL INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your "protected health information" ("PHI") to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. We will explain each category and give some examples where necessary. Not every use or disclosure in a category will be listed. This Notice also describes your rights and obligations regarding the use and disclosure of medical information. "Protected health information" is the information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your medical providers, office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services pertaining to your care. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Another example is that your protected health information may also be disclosed to your physician who referred you to therapy services in order to effectively manage your case.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining authorization for medical and/or therapy services may require that your relevant protected health information be disclosed to the health plan or insurance carrier to obtain approval for the medical and/or therapy services.

Research Purposes: Your protected health information may be used to determine the efficacy of your treatment. In this case, information that identifies you will be removed so others may use your PHI to study healthcare and delivery without learning the identity of the specific patients.

Healthcare Operations: We may use or disclose your protected health information to carry out activities that are necessary to run our facilities and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Contacts and Appointment Reminders: We may use or disclose your protected health information, as necessary, when calling to inform you of appointments or information about treatment alternatives or other health-related benefits and services.

Emergencies: We may use or disclose your protected 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.

Miscellaneous: We may use or disclose your protected health information without your authorization for several other reasons. These situations include, as required by law: public health issues as required by law; communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroner; funeral directors and organ donation; research; criminal activity; military activity and national security; workers compensation; inmates; and other legally required uses and disclosures. Under the law, we must take disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Workers' Compensation: By law, we may use or disclose your protected health information without your authorization for payment purposes and for other reasons required by law, including, without limitation, to provide medical reports and work restrictions to you and to your employer, to the extent required or allowed by Colorado workers' compensation laws. For example, your protected health information may be used or disclosed to your workers' compensation insurance carrier or for such activities as billing, determinations of eligibility or coverage, and review of health care services with respect to medical necessity, appropriateness of care, justification of charges, or those necessary for preauthorization of services.

Other Permitted and Required Uses and Disclosures: Other uses and disclosures will be made only with your written authorization and you may revoke such authorization as provided by law.

You may revoke this authorization, at any time, in writing, except to the extent that Arbor, Alpha and MBF have taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

Right to Inspect and Copy: In most cases, you have the right to inspect or copy your medical information when you submit a written request. We may deny your request in certain circumstances. If you are denied access to your medical information, you may appeal.

Right to Amend: If you believe the information in your record is incorrect or incomplete, you have the right to request an addendum be added to your record by submitting a written request giving your reason. We may deny your request in certain circumstances. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to Request Restrictions: You have the right to request that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and must state the specific restriction requested, whether you want to limit our use or disclosure or both, and to whom you want the restriction to apply.

We are not required to agree to your request for a restriction, but we will consider it. For example, if a provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. Another example is that we cannot agree to certain restrictions on use or disclosure of certain PHI in workers' compensation cases.

Right to Request Confidential Communications: You have the right to request that your medical information be communicated to you in a confidential manner, such as sending mail to an address other than your home. Your request must be submitted in writing to us.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice of Privacy Practices upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

Right to an Accounting of Disclosures: You have the right to a list of those instances where we have disclosed your medical information other than for treatment, payment, healthcare operations or where you specifically authorized a disclosure. To request an accounting of disclosures, you must submit a written request.

Changes to this Notice: We reserve the right to change this notice at any time. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as for any information we receive in the future. We will post a copy of our current Notice within our facilities and also on our website.

Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. Your complaint must be in writing and must include the details of the basis for your complaint. Your complaint must be submitted to our HIPAA compliance officer (please call our Broomfield office at 303-460-9151 for the identity of that officer). You will not be retaliated against for filing a complaint.

This version is effective as of **September 1st, 2011**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our Broomfield office at 303-460-9151.

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of our Notice of Privacy Practices. We encourage you to review it carefully. Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised Notice upon request.

I acknowledge receipt of this Notice of Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

Reason(s) why the acknowledgement was not obtained:

___ Patient refused to sign.

___ Other

comments: _____

