PATIENT INTAKE FORM

REFERRED BY: _____ FIRST VISIT: _____

PATIENT NAME _____ SS# _____

ADDRESS _____ CITY _____STATE_____

ZIP CODE_____ HOME #_____WORK/CELL # _____

D.O.B. _____E-MAIL _____

EMPLOYER _____ PH#_____

SPOUSE'S EMPLOYER_____ PH# _____

DIAGNOSIS/CHIEF COMPLAINT _____

REFERRING PHYSICIAN _____ OFFICE # _____

PRIMARY PHYSICIAN _____ OFFICE # _____

EMERGENCY NAME/NUMBER:_____

Patient Name: _____

ASPEN
After Surgery Center

Patient History Questionnaire (Liposuction or Tummy Tuck)

Date of your last procedure AKA Liposuction or Tummy Tuck: _____

How long after procedure did you notice a change/problem? _____

Onset date of your change/problem: _____

Have you had this problem before? Yes ☐ No ☐

What type of changes occurred?

(Please check all that apply to you):

Pain ☐ Scar ☐ Lumpy & Bumpy ☐ Firmness ☐ Other ☐

If other, please explain_____

Patient's Past Medical History

Please check all that apply to you:

Diabetes	☐	Pacemaker/ implantable defibrillator	☐
Cancer	☐	Hypertension/High Blood Pressure	☐
Heart Disease/Angina	☐	Shortness of Breath/ Asthma	☐
Allergies (Medication)	☐	Stroke	☐
Are you allergic to Latex?	☐	Osteoporosis/ Rib /Spine fractures in past	☐
Balance Disorders	☐	If applicable, are you pregnant?	☐

After / Before Procedure do/ did you?

Have excessive bruising / black and blue marks: Yes ☐ No ☐

Smoke/Use Tobacco: Yes ☐ No ☐

Have infection in area of procedure/ incision: Yes ☐ No ☐

Sustain trauma or injury to area: Yes ☐ No ☐

Have Seroma or Hematoma drained: Yes ☐ No ☐

Type of Procedure done: _____

What areas was procedure done AKA tummy, tights, back _____

Other issues you feel relates to start of condition_____

Patient Name: _____

What are your goals in coming to therapy? _____

How are you limited in your day-to-day activities? _____

Cultural/Religious- Any customs or religious beliefs or wishes that might affect care? _____

Occupation: _____

Do you exercise regularly? Yes ☐ No ☐ If yes, how often? _____ How long? _____

What type of exercise do you do?_____

What difficulties do you have?_____

Please list all medications you are currently taking:

_____ _____
_____ _____
_____ _____

Please list any surgeries/procedures you have had (chronological order) and the date(s) of that surgery below:

_____ _____
_____ _____
_____ _____

1. On a scale from 0-10 (**10 being worst** hardness and **0 normal** softness) what number would you say your procedure area firmness is now? (Please Circle):

0	1	2	3	4	5	6	7	8	9	10

2. On a scale from 0-10 (**10 being worst** visible looks and **0 normal** visible looks) what degree would you say your procedure are is now? (Please Circle):

0	1	2	3	4	5	6	7	8	9	10

PAIN BEHAVIOR:

Please **CHECK** any items below that apply to you.

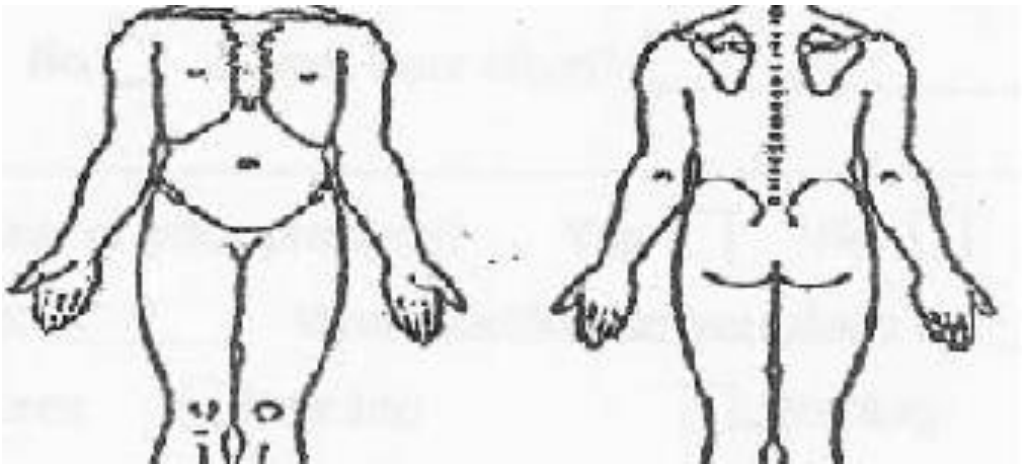
Aching ☐	Throbbing ☐	Sharp ☐	Firmness ☐
Electric/Shooting ☐	Tightness ☐	On/Off ☐	

Your pain is worse: Please **CHECK** any items below that apply to you.

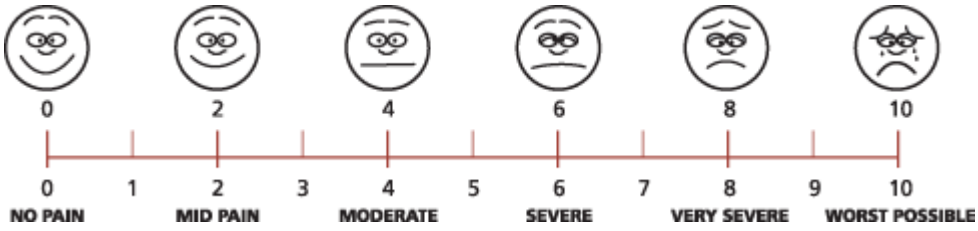
Sitting ☐	Exercising ☐	Standing ☐	Lying on tummy ☐	Lying on side ☐
In AM ☐	As day progresses ☐	In PM ☐	At rest ☐	Bending ☐

Patient Name: _____

Mark on the drawing below the areas where you feel your issue or where your problem area is:



Please circle the number that reflects your level of pain today.



Signature: _____ Date: _____

Broward County, Florida

CONSENT TO PHOTOGRAPH

The Undersigned does hereby authorize ASPEN REHABILITATION TECHNOLOGIES, LLC to photograph or permit other persons to photograph (**Print name**) _____ while a patient, and agrees that they may use or permit other persons to use the negatives or prints prepared there from for such purposes as evaluation of progress, treatment, research, and in such manner as may be deemed necessary. This consent is expressly intended to release from liability all of the above-named facility's personnel and consultants.

Photograph to be taken by Aspen Rehab Technologies, LLC Staff.

Purpose of photograph is for Research, Document Progress, and share with physician.

Signed _____
Patient to be photographed

_____
Witness

_____
Date

_____
Hour

PATIENT CONFIDENTIALITY, NON-DISCLOSURE, and NON-COMPETE AGREEMENT

The following is a CONFIDENTIALITY, NON-DISCLOSURE, and NON-COMPETE AGREEMENT with ASPEN REHAB TECHNOLOGIES, LLC (hereafter referred to as the 'Company'), and I (Print), _____ (hereafter referred to as "Patient") this agreement is in consideration for providing treatment services as a patient I agree to the following.

I agree at all times during treatment, discussion, training, and as a patient with the Company, to hold in strictest confidence, and not to use, except for the benefit of the Company, or for the direct treatment of myself, the patient, to not disclose to any and all staff members of my referring physician, physician partners, other medical professionals, persons, firms, or corporations without written authorization from Tim Weyant, CEO Aspen Rehab Technologies, LLC, any Confidential Information of the Company.

I understand Confidential Information includes treatment techniques, manual therapy maneuvers, massage techniques, medical equipment treatment parameters or protocols including, but not limited to: Ultrasound usage or E-stim applications, and bandaging and compression garment techniques. I also agree not to compete or disclose to: referring physicians, referral sources, data, trade secrets, or knowledge, including but not limited to: research, product plans, products, services, customer lists and customers (including, but not limited to: customers of the Company on whom I called or with whom I became acquainted during the term of business), markets, software, developments, inventions, processes, formulas, technology, designs, drawings, engineering, hardware configuration information, marketing, finances, and other business information disclosed to me by the Company, either directly or indirectly in writing, orally, or by drawings or observation of parts or equipment.

I further understand that Confidential Information does not include any of the foregoing items if they have become publicly known and made generally available through no wrongful act of the Patient, or others who were under confidentiality obligations as to the material involved. This includes already established referral sources, physician's offices, and marketing programs, established by the Patient, prior to commencement of business with the Company.

I agree that I will not, during discussion, training, and treatment as a Patient, improperly use or disclose any proprietary information or trade secrets to any former or concurrent employer or business entity. This includes use or disclosure to any and all members of licensed and unlicensed staff, friends, or family members of the Patient. I will not bring onto the premises of the Company any unpublished document or proprietary information belonging to any such employer, person, or entity unless consented to in writing by such employer, person, or entity. I understand that the aforementioned proprietary information is held as patent protected within these United States and enforceable under United States Patent law.

I agree that during discussion, training, and treatment as a Patient, or should treatment be terminated by either party, I will deliver to the Company (and will not keep in my possession, recreate, or deliver to anyone else) any and all documentation, notes, items developed or supplied by the Company, and Tim Weyant, pursuant to discussion with the Company or otherwise belonging to the Company, its successors, or assigns.

At all times while this agreement is in force and after its expiration or termination, I agree to refrain from competing with, disclosing, or soliciting the Company's referring physicians, public markets including print, radio, or television, customer lists, trade secrets, or other confidential material. I agree to take reasonable security measures to prevent accidental disclosure and industrial espionage.

While this agreement is in force, I agree to use my best efforts at performing his/her job, and to abide by the non-disclosure and non-competition terms of this agreement.

After expiration or termination of this agreement, I agree not to compete with the Company and/or Tim Weyant unless express written authorization has been given by the Company.

IN WITNESS, a representative of the Company and I have signed this agreement.

Patient, Representative
Name:

Signature Date:

For The Company

Signature: Date:

ASPEN
After Surgery Center

Authorization to Release Medical Information/HIPPA Compliance

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize the release of the following protected health information:

□ **Name of Plastic Surgeon** _____

□ Other: _____ □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is:

□ **Treatment** □ Other (specify) _____

Send my medical information to: Name: _____

Address: _____

City, State, Zip: _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for healthcare.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Aspen Rehabilitation shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be release contains any information about HIV/AIDS and additional HIPPAA release of medical Information for will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released
- A copy of this signed form will be provided to me.
- Aspen Rehabilitation may charge and administrative fee to cover cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization Expires on _____/____/____ (if date not completed/ one year after signed)

Patient/ Representative Signature _____ Date: _____