Date: _____

Full Name: _____

Date of Birth: _____ SSN: _____ Age: _____ Sex: _____

Marital Status: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Are You COG, COG Restore or VIGI Employee? Yes ☐ No ☐

If no, are you the spouse or partner of a COG, COG Restore or VIGI employee? Yes ☐ No ☐

Are you a Veteran? Yes ☐ No ☐

Emergency Contact Name: _____ Phone: _____

Guaran tor Information: (Information of person financially responsible for a minor under age 18)

Guarantor Name: _____ Relationship to Patient: _____

SSN: _____ Date of Birth: _____ Sex: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Guarantor Address: _____

City: _____ State: _____ Zip Code: _____

Insurance / Subscriber Information

Primary Insurance: _____ Policy ID #: _____

Group #: _____ Effective Date: _____

Subscriber Name: _____ Subscriber SSN: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance: _____ Policy ID #: _____

Group #: _____ Effective Date: _____

Subscriber Name: _____ Subscriber SSN: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

I would Like to receive Text reminders of my appointment: Yes ☐ No ☐

Is your injury related to an auto accident and/or another accident? Yes ☐ No ☐

Do you have a Case/Claim related to this injury? Yes ☐ No ☐

If yes, please provide the Front Desk with accident claim information.

Reason for visit: _____

Referring Physician: _____ Referring Physician Phone: _____

Consent to Evaluate and Treat:

I do hereby consent to the evaluation and treatment by COG Restore. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Name: (please print): _____

Signature: _____ Date: _____

(TURN OVER)

Financial Responsibility:
I give COG/ COG Restore permission to bill my insurance company and I am aware that there may be costs/co-payment associated with the services I am seeking from COG Restore that my insurance company may not cover. I understand that any balances due will be my responsibility and will be paid in a timely manner.

Name: (please print): _____

Signature: _____ Date: _____

Notice of Privacy Practices and Statement of Non-Discrimination:
I have read COG Restore's Notice of Privacy Practices and Statement of Non-Discrimination. I am familiar with how my health information will be used. I am aware that I may request a copy of the Notice of Privacy Practices at any time. I am aware of the free aids and services available to me and how to request assistance to better participate in my care.

Name: (please print): _____

Signature: _____ Date: _____

Patient Rights and Responsibilities

Please read thoroughly and initial where indicated. Thank you.

COG Restore is dedicated to service the whole patient regardless of race, creed, social or economic status, believing that the right sand dignity of every patient must be protected and promoted with care. This facility will protect patient's rights to privacy and keep patient records and communications confidential, in accordance with professional ethics and the law. COG Restore is committed to safeguarding the right of each patient to information about and participation in decisions regarding medical care, and to promote respect and dignity for all individuals. In the case of a minor, the following rights and responsibilities are afforded to the patient parent or guardian.

YOU HAVE THE RIGHT TO:

- Considerate and respectful care, which optimizes your comfort and dignity throughout our treatment.
- Access to treatment regardless of gender, age, disability, ethnicity and religion.
- Participate in the consideration of ethical issues that arise in the course of your care.
- Receive information about, and an explanation of your bill.
- Request a copy of your complete medical record and obtain the copy within a reasonable timeframe and cost.
- Be treated by skilled, compassionate caring therapists and staff.
- Know the names and roles of the providers caring for you.
- Be well informed about your ailment, possible treatments, likely and unanticipated outcome, sand to discuss this information with your healthcare provider.
- Receive a high standard of patient care and safety while in the facility. This facility, your doctor, and health care professionals will protect your safety and security as much as possible.
- Act in partnership with your healthcare providers to make decisions regarding your care.
- Informed consent including the right to have treatment options explained so that you understand the benefits, risks, and treatment choices.
- Refuse treatment to the extent permitted by ethics and law, and to be informed of the medical consequences of your action.

IT IS YOUR RESPONSIBILITY TO:

1. **BE A PART OF YOUR CARE**
   - Be as accurate and complete as possible when providing medical history and treatment information.
   - Inform your healthcare provider if you have any questions regarding care and treatment.
   - Partner with the health care providers to develop an appropriate plan of care.
   - Participate in the designated plan of care.
   - Notify your heath care providers if the designated plan of care cannot be followed.
   - Notify us immediately if your insurance carrier or plan changes.
2. **BE ON TIME FOR YOUR APPOINTMENTS**
   - Being 10 minutes late or more may be considered a "No Show" and your appointment may have to be rescheduled. _____(Initial)
   - Call to cancel or reschedule your appointments. No call/No show 3 times may lead to discharge. Once discharged you will have to obtain a new referral before returning for further therapy. _____(Initial)
   - No appointments for two to four consecutive weeks may lead to discharge. Once discharged you will have to obtain a new referral before returning for further therapy. _____(Initial)
   - Please be advised that there will be a "No Show" fee of $25 if you do not call to reschedule your appointment within a minimum of 24 hours prior to your appointment time. _____(Initial)
3. **BE FINANCIALLY SOUND**
   - Payments/Co payments are due at the time of service unless other arrangements are made.
   - Cash, checks and credit cards (Visa, Mastercard)are accepted. Return check fee is $30.00 _____(Initial)
4. **RESPECT AND CONSIDER THE RIGHTS OF OTHERS**
   - Be considerate of the rights of other patients and their families.
   - It is advised that children not attend therapy sessions with you. If they do, please be aware they are NOT permitted on any of the equipment. This is for their own safety.
   - Be considerate of the therapists and health center staff.
   - Provide the facility with accurate and timely information concerning the sources of payment and ability to meet financial obligations associated with care.
   - The single most important way you, as a patient, can help to prevent errors is to be an active member of your health care team. SPEAK UP if you have any questions or concerns.

EMAIL AUTHORIZATION AGREEMENT

COG RESTORE may choose to discontinue ema il communication to you at any time.

Privacy and security with e-mail

Do NOT e-mail us or request from us sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, any e-mail sent on your employer's system may be viewed by your employer.

COG RESTORE cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e- mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your health care provider through e-mail.

This document along with COG RESTORE 's "Notice of Privacy Practices" constitutes a notice of privacy practices for e-mail use.

Authorization to use e-mail

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of email as one form of communication with my health care providers of COG RESTORE.

Patient's E-mail Address: _____

Patient Name (Print): _____ Date: _____

Patient 's Signature: _____

Patient Representative (Print): _____ Relationship: _____

Patient Representative's Signature: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USE D AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

COG Restore is required by law to maintain the privacy of Protected Health Information ("PHI") and to provide you with notice of our le ga l duties and privacy practices with respect to PHI. PH I is 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. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI. We are required to provide this notice to you by the Health insurance Portability and Accountability Act ("HIPAA").

COG Restore is required to follow the terms of this Notice. We will not use or disclose your PHI without your written authorization, except as described or otherwise pem1itted by this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Examples of How We Use and Disclose Protected Health Information About You

The following categories describe different ways that we use and disc lose your protected health information. We have provided you with examples in certain categories; however, not every use or disclosure in a category will be listed.

Treatment: We may use your health infom1ation to provide and coordinate the treatment, medications and services you receive. Payment: We may use your health information for various payment-related functions. Example: We may contact your insurer or other health care payer to determine whether it will pay for your treatments and the amount of your co-payment. We will bill you or a third-party payer for the cost of your treatments. The information on or accompanying the bill may include information that identifies you.

Health Care Operations: We may use your health information for certain operational, administrative and quality assurance activities.

Example: We may use information in your health record to monitor the performance of the clinician providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the health care and service we provide. We may disclose health information to business associates if they need to receive this information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of health information.

We may also use your health information to provide you with information about benefits available to you, and, in limited situations, about health-related products or services that may be of interest to you.

We are permitted to use or disclose your PHI for the following purposes. However, COG Restore may never have reason to make some of these disclosures.

To Communicate with Individuals Involved in Your Care or Payment for Your Care. We may disclose to a family member, other relative, close personal friend or any other person you identify, PHI directly relevant to that person's involvement in your care or payment related to your care.

Food and Drug Administration (FDA). We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplement s, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health. As required by law, we may disclose your PH I to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement. We may disclose your PHI for law enforcement purposes as required by law or in response to a subpoena or court order.

As Required by law, we will disclose your PHI when required to do so by federal, state, or local law.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the infom1ation requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PH1 to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Organ or Tissue Procurement Organizations. Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Notification. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, regarding your location and general condition.

Correctional Institution. If you are or become an inmate of a correctional institution, we may disclose to the institution or its agents PHI necessary for your health and the health and safety of other individuals.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

National Security. Intelligence Activities, and Protective Services for the President and Others. We may release PHI about you to federal officials for intelligence, counterintelligence, protection to the President, and other national security activities authorized by law.

Victims of Abuse or Neglect. We may disclose PHI about you to a government authority if we reasonably believe you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

Other Uses and Disclosures of PHI

We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Obtain a paper copy of the Notice upon request. You may request a copy of our current Notice at any time. You may obtain a paper copy from the COG Restore office.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the COG Restore office. We are not required to agree to those restrictions. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business.

Inspect and obtain a copy of PHI. In most cases, you have the right to access and copy the PHI that we maintain about you. To inspect or copy your PHI, you must send or submit a written request to COG Restore. We may charge you a fee of$3.00 per page and $10.00 per hour for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. To request an amendment, you must send or submit a written request to COG Restore. You must include a reason that supports your request. In certain cases, we may deny your request for amendment.

Receive an accounting & of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of your PHI after April 14, 2003 for most purposes other than treatment, payment, or health care operations. The right to receive an accounting is subject to certain exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to COG Restore. Your request must specify the time period. The time period may not be longer than six years and may not include dates before April 14, 2003.

Request communications of PHI by alternative means or at alternative locations. For instance, you may request that we contact you at a different residence or post office box. To request confidential communication of your PHI, you must submit a request in writing to COG Restore. Your request must tell us how or where you would like to be contacted. We will accommodate all reasonable requests.

Incidental Disclosures

COG Restore will make reasonable efforts to avoid incidental disclosures of protected health information. An example of an incidental disclosure is conversations that may be overheard between COG Restore clients and staff in the patient care areas. To reduce the likelihood of this happening, we recommend that you ask for a private room for any consultations.

Minors

If you are a minor who has lawfully provided consent for treatment and you wish for COG Restore to treat you as an adult for purposes of access to and disclosure of records related to such treatment, please notify us.

For More Information or To Report a Problem

If you have questions or would like additional information about COG Restore privacy practices, you may contact us at Royal Palms Professional Bldg, Ste 206, 9053 Estate Thomas, VI 00802 or by telephone at 340-779-9355. If you believe your privacy rights have been violated, you can file a complaint with COG Restore. There will be no retaliation for filing a complaint.

Statement of Non-Discrimination

COG Restore complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. COG Restore does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

COG Restore provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, accessible electronic formats, other formats)

COG Restore provides free language service s to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact our office:

COG Restore

9053 Estate Thomas, Royal Palms Ste 206

St. Thomas, VI 00802

Tel: 340-779-9355 Fax: 340-779-9350

If you believe that COG Restore has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

COG Restore

9053 Estate Thomas, Royal Palms Ste 206

St. Thomas, VI 00802

Tel: 340-779-9355 Fax: 340-779-9350

You can file a grievance in person or by mail or fax. If you need help filing a grievance, we have staff available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW., Room 509F, HHH Building

Washington, DC 20201

1-800-868-1019, 800-537-7697 (TDD).