CONSENTS, AUTHORIZATIONS, AND RELEASES for physical therapy patients

Patient Name: ______________________________ Date: ______________

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html. A complete copy of the Florida Health Notice of Privacy Practices is available here: http://www.floridahealth.gov

1. I understand and agree to allow this office to use my PHI for the purpose of treatment, health care operations and coordination of care.
2. I have the right to examine and obtain a copy of my health records at any time and request corrections. I may request to know what disclosures have been made, and submit in writing any further restrictions on the use of my PHI. This office is not obligated to agree to those restrictions.
3. My written consent shall remain in effect for as long as I receive care at this office, regardless of the passage of time, unless I provide written notice to revoke my consent. A revocation of consent won't apply to any prior care of services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. I have the right to file a formal complaint with GET PHYSICAL LLC about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial: _________

Consent to Professional Treatment

I hereby consent to receive care for physical therapy, wellness or fitness services by GET PHYSICAL LLC. I consent to medical treatment as is deemed necessary or advisable by the physical therapist. If the patient/client is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial: _________

Financial Agreement

I understand I am responsible to GET PHYSICAL LLC for all charges incurred at the time of service. I understand I may request a bill for physical therapy services provided and that it is my responsibility to personally submit the bill to my insurance. I understand GET PHYSICAL LLC is making no guarantee of reimbursement or partial reimbursement to me from my insurance.

Initial: ________

Consent to Release Medical Information

I authorize GET PHYSICAL LLC to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), my physician(s).

Initial: ________

Consent to Obtain Medical Information

I authorize GET PHYSICAL LLC to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-Rays, CAT Scans, MRI reports along with Physician's Documentation.

Initial: _______

I hereby certify that I have read and understand everything presented on this page.
I hereby also certify that I have received Notice of Privacy Policy for Get Physical LLC.

Patient/Responsible Party Signature: ______________________ Date: _____________

*GET PHYSICAL LLC * 2700 SE 2nd St * Pompano Beach, FL 33062 * 954-412-8484*

RELEASE OF LIABILITY (client/legal representative)

- I assume full responsibility while voluntarily participating in a physical therapy session and/or a health and wellness program at my sole risk and shall abide by rules and regulations specified by the owner or instructor regarding use of the facility and equipment.
- I am aware that there exists the possibility of certain conditions during or following exercise. These might include, but are not limited to: light-headedness, fainting, abnormalities of heart rate or blood pressure, ineffective heart function, and potentially heart attack or stroke.
- It is strongly recommended that I receive medical clearance from my primary physician prior to beginning a new exercise program.
- I hereby release GET PHYSICAL LLC, its instructors, owners and other participants, from any liability for injury or damages while using the facilities located at 2700 SE 2nd Street, Pompano Beach, FL 33062. GET PHYSICAL LLC will not be subjected to any claim, demand, injury or damages whatsoever, including, without any limitation to those damages resulting from acts of active or passive negligence on the part of GET PHYSICAL LLC, its owners, agents, contractors, employees or other participants. The client, for him/herself and on behalf of his/her executors, administrators, heirs and successors does hereby expressly forever release and discharge GET PHYSICAL LLC, its owners, agents, assigns and successors from all such claims, demands, injuries, damages, actions or causes of action to the fullest extent permitted by law. I also agree that GET PHYSICAL LLC is not responsible or liable to clients for articles damaged, lost or stolen in or about the facility.
- As a courtesy to other patients/clients who might be sensitive or allergic, please do not use perfumes or colognes.

Initial: _________

CANCELLATION POLICY

A minimum of **<u>24 hours notice</u>** is required to cancel your appointment. If you need to cancel a Monday appointment, you must call the morning of the Friday prior. Because I schedule only one patient per hour, this allows me to fill any cancellations with patients on my waiting list. Unforeseen events do happen, which is why one late cancellation or no-show is allowed during your episode of care. Future late cancellations and any no-shows will incur full charge of missed appointment payable on the day of your next appointment. All pre-paid services, including but not limited to multiple session packages, are non-refundable and must be used within the allotted time. Any unused portions not used within the allotted time frame will be forfeited.

Initial: _________

I have read the above statements and my signature indicates my full participation and agreement for services at GET PHYSICAL LLC. I have read this release of liability and assumption of risk agreement and fully understand its terms. I am signing this Release of Liability freely and voluntarily without any inducement.

Patient/Responsible Party Signature: ____

Printed Name: _____________________________ Date: ___________________

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