Informed Consent for Physical Therapy Services

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, active release techniques/massage, strength training, cardiovascular training, and physical agents/modalities in an attempt to accelerate recovery and restore independent function.

All procedures will be thoroughly explained to you before you are asked to perform them. There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing levels of difficulty that could increase your level of pain or discomfort with a current or previous injury. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment. You will be able to stop treatment if you feel any discomfort or pain. Your therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established.

I grant permission or on behalf of myself or the minor listed below, and consent to Clubhouse Athletics LLC and Performance Rehabilitation and Strength LLC for the use of photograph(s) and video(s) for presentation under any legal condition, including but not limited to: publicity, advertising (print, digital and social media) and web content.

I have read the consent form and authorize the release of medical information to appropriate third parties. I hereby release Clubhouse Athletics LLC and Performance Rehabilitation and Strength LLC from any responsibility or liability due to my participation in physical therapy. I am fully aware that I am participating in these sessions at my own risk and will not hold the named above responsible in the event of my incurring an injury or exacerbating any previously existing conditions. If I have any medical conditions, I have consulted with my physician to make sure that physical therapy is appropriate for me to participate in.

______________________________________ ________________________

Patient Signature Date

______________________________________ ________________________

Parent or Guardian Signature (if patient is under age 18) Date

Patient Information

Name: ____

Mailing Address: ____

Phone: ____________________________ Date of Birth: __________________________

Email: ____________________________ Date of Last Physical: __________________________

School District/College: ____

Emergency Contact and Phone: ____

Referring Physician and Phone: ____

Referral Source (If Other Than Physician): ________________________________

Club/Travel Team Coach and Email: _______________________________________

____ ________________________

Patient Signature Date

____ ________________________

Parent or Guardian Signature (if patient is under age 18) Date

Consent to Communicate

I understand that authorized personnel from Performance Rehabilitation and Strength LLC may communicate with me regarding scheduling, the treatment being provided, educational information including newsletters as it relates to health-related products or services available from Performance Rehabilitation and Strength LLC, or alternative treatments, providers. I agree to receive such communication via email at the following email address:

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Email Address

_______________________________________ ________________________

Patient Name Date

_______________________________________ ________________________

Parent or Guardian Signature (if patient is under age 18) Date

Office Policies

Insurance Option

I hereby authorize Performance Rehabilitation and Strength LLC, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize Performance Rehabilitation and Strength LLC to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text messaging. I am assigning my therapy benefits to Performance Rehabilitation and Strength LLC for the services in which I receive and authorize my insurance carrier to make payments to Performance Rehabilitation and Strength LLC on my behalf. Performance Rehabilitation and Strength LLC reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. Performance Rehabilitation and Strength LLC is HIPAA compliant with regard to information sharing policies. By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

Cash Pay Option

All patients must recognize that they are responsible for the charges incurred for physical therapy **at the time of service** at a rate of $120 per hour for initial evaluations and $100 per hour for follow up visits. Physical Therapy services performed by Performance Rehabilitation and Strength LLC will be billed as an out-of-network service. Because they fall under a medical expense that treats the structure and function of the body, you are able to use your HSA/FSA funds to pay for treatment for yourself, your spouse, or your dependents. A "superbill" will be sent to you electronically with all pertinent information required for reimbursement upon submittal to your insurance company. Contact your insurance provider if you have questions about the amount covered for out-of-network physical therapy services; this will vary among providers and plans.

Should you ever need to cancel your session, you may do so outside of your 24-hour time period. If you no-show or cancel within 24 hours of your session for any reason (other than weather or illness related) a $50 cancel fee will be enforced. By signing this document, you have acknowledged the cancellation policy and will abide by it. If you need to cancel within 24 hours, it is expected for you to acknowledge the policy during the time of cancellation with intention to abide by it.

I authorize this office to release any information pertinent to my case to any insurance company, billing service, adjuster, or attorney to facilitate collection under this assignment and authorization.

______________________________________ ________________________

Patient Signature Date

______________________________________ ________________________

Parent or Guardian Signature (if patient is under age 18) Date

Credit Card Authorization

Performance Rehabilitation and Strength LLC require payment on the day of your visits; patients can bring payment on the day of the treatment or we can keep your credit card on file for payment. This form will be kept confidential and only authorized staff has access to the information and is stored in our secure payment processing website.

Name as it Appears on Card: ____

Card Number: ____

Security Code: ____

Expiration Date: ____

Billing Zip Code: ____

I acknowledge and authorize Performance Rehabilitation and Strength LLC to charge the above credit card account for any Physical Therapy services or cancellation/no show fees. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured, I authorize payment at time of service. I agree to update any information regarding this credit card account.

____ ____________________________

Card Holder Signature Date

Past Medical History

Name: ____ Date: _____________

Describe current level of physical activity:

Check which one applies to your condition:

() Motor vehicle accident () Recurrence of previous injury () Athletic/Recreational Injury
() Work-Related injury () Injured from a fall () Other:

Have you ever had these symptoms before?

Date of surgery (if applicable):

Tobacco and/or alcohol use:

Are you currently being treated, or have you been treated by another medical professional for the same injury? Identify all specialties if applicable:
____
____

Do you have or have you had any of the following? Identify all that apply:

Unusual Headache
Osteoporosis
Hernia
Seizures
Metal Implants
Dizziness/Fainting
Fracture
Surgeries
Sudden Loss of Balance
Ringing in Ears

Loss of Appetite
Unexplained Fever/Chills
Unexplained Vision Changes
Pacemaker
Chest Pain/Angina
Heart Disease/Attack
High Blood Pressure
Cancer/Tumor
Kidney Problems

Stroke
Bowel/Bladder Incontinence
Pregnancy
Breathing Difficulties
Liver/Gallbladder Problems
Hypoglycemia /Diabetes
Osteoarthritis/Rheumatoid
Rheumatic Arthritis
Sensitivity to Heat/Cold

If you identified any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.
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Past Medical History Continued

If you are currently taking any medications, please list them along with the pathology.

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____

Within the past year, have you had any of the following tests? Identify all that apply:

Angiogram
Arthroscopy
Biopsy
Ultrasound
X Ray
Venous Doppler Test

EEG (electroencephalogram)
EKG (electrocardiogram) EMG
(electromyogram) Bone Scan
Pulmonary function test

Spinal Tap
Stress Test
MRI/MRA
CT Scan
Myelogram

If you identified any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

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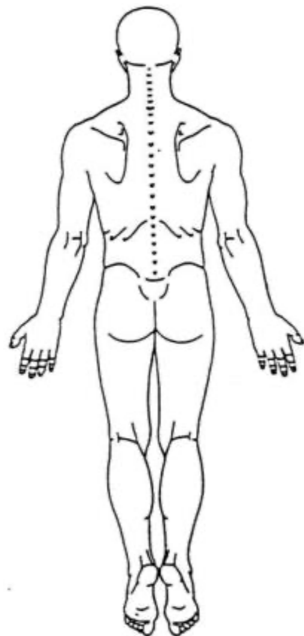
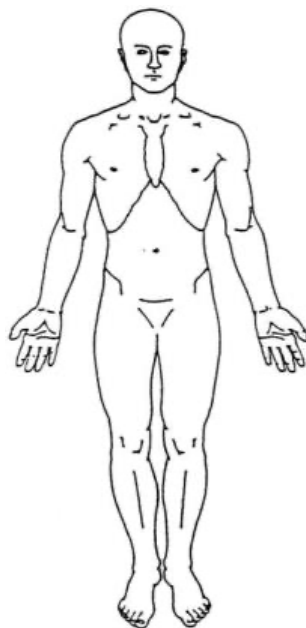
____

We may request from your physician any reports indicated above and other information that would be helpful in the course of your treatment

Body Chart

Please identify the location and nature of your symptoms:





() Numbness/Tingling

() Stabbing

() Throbbing

() Sharp

() Deep Ache

() Dull

() Tight

() Weak/Fatigued

() Shooting

Dry Needling Consent & Information Form

Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chinese meridians for the treatment of diseases. Dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low-back pain.

Please answer the following:

1. Have you ever fainted or experienced a seizure — YES / NO
2. Do you have a pacemaker or any other electrical implant — YES / NO
3. Are you currently taking anticoagulants (blood-thinners e.g., aspirin, warfarin, coumadin) — YES / NO
4. Are you currently taking antibiotics for an infection — YES / NO
5. Do you have a damaged heart valve, metal prosthesis or other risk of infection — YES / NO
6. Are you pregnant or actively trying for a pregnancy — YES / NO
7. Do you suffer from metal allergies — YES / NO
8. Are you a diabetic or do you suffer from impaired wound healing — YES / NO
9. Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease — YES / NO

STATEMENT OF CONSENT

I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I hereby release Clubhouse Athletics LLC and Performance Rehabilitation and Strength LLC from any responsibility or liability due to my participation in this treatment. I am fully aware that I am participating in these sessions at my own risk and will not hold the named above responsible in the event of my incurring an injury or exacerbating any previously existing conditions. If I have any medical conditions, I have consulted with my physician to make sure that this service is appropriate for me to participate in. I understand that this is a $50 cash service and is not eligible for insurance reimbursement. I acknowledge that this is introductory pricing and subject to change in the future.

____________________________________ ____________________

Patient Signature — Date

____________________________________ ____________________

Parent or Guardian Signature (if patient is under age 18) — Date

HIPPA Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Clubhouse Athletics LLC and Performance Rehabilitation and Strength LLC ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

Uses and Disclosures with Patient Consent: Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

Treatment. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.

Payment. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

Health Care Operations. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

Uses and Disclosures with Patient Authorization. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

Uses and Disclosures with Patient Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's

involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

Uses and Disclosures Required by Law. We will disclose your health information when required to do so by law.

Public Health Activities. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

Abuse and Neglect. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

Regulatory Agencies. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

Judicial and Administrative Proceedings. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

Law Enforcement Purposes. We may disclose your health information to law enforcement officials when required to do so by law.

Coroners, Medical Examiners, Funeral Directors. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

Research. Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

Threats to Health and Safety. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

Military/Veterans. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

Workers' Compensation. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Marketing. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.

Appointment Reminders. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

Other Uses and Disclosures. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

Uses and Disclosures to Business Associates. With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your own health information upon request; it may be in electronic or paper format. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

Right to Verbally Object. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment, or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

Right to Seek an Amendment of Your Health Information. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

Right to an Accounting of Disclosure of Your Health information. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The

accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

Right to Confidential Communications. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

When Authorizations are Required. An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.

Right to Revoke Your Authorization. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

Right to Opt-Out of Fundraising Communications. We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications. You can do so in writing by sending an email to agperformancept@gmail.com with your instructions to opt out of fundraising communications.

Right to be Notified Following a Breach of Your Information. If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.

Right to Receive Copy of this Notice. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact us at agperformancept@gmail.com. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact us at agperformancept@gmail.com. All complaints must be submitted to the Practice in writing at 301 Pleasant Street, Abbottstown, PA 17301. There will be no retaliation for filing a complaint.

Privacy Policy Effective Date

The effective date of this Notice is March 18, 2023.

______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Parent or Guardian Signature (if patient is under age 18)	Date