Privacy Policy, Conditions and Consent to Treat for Physical Therapy

I understand that my child is a patient of Fit Family Physical Therapy, LLC.

Informed consent for treatment:
The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services, and I understand that I will receive information at the initial visit concerning the treatment and options available for my child's condition.

Fit Family Physical Therapy, LLC provides specialized treatment that consists primarily of manual therapy techniques, therapeutic exercise programs, therapeutic activities, neuromuscular re-education, as well as other treatment modalities. Your therapist will review your child's plan of care and discuss these treatment options with you in order for you to provide specific consent. The number of treatments needed and recovery time can both vary due to nature of injury or condition, medical history, age of patient and many other contributing factors.

No warranty:
I understand that Fit Family Physical Therapy, LLC cannot make any promises or guarantees regarding a cure for or improvement in my child's condition. I understand that my therapist will share with me his or her professional opinions regarding potential results of physical therapy treatment for my child's condition and will discuss treatment options with me before I consent to treatment.

Liability:
I understand and agree that Fit Family Physical Therapy, LLC is not responsible for loss or damage to personal valuables.

Waiver and Release:
I hereby release, discharge and acquit Fit Family Physical Therapy, LLC, its agents, representatives, affiliates and employees, from any and all liability, claim, demand, damage, cause of action or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services including, but not limited to, ambulance service, emergency medical technician or paramedic services, and physician or urgent care services for my child.

I hereby give authorization and consent for my child to be treated by Fit Family Physical Therapy, LLC for the medical condition/injury for which I have sought consultation. In doing so, I voluntarily consent to the rendering of such care within the physical therapy scope of practice by the state of Arizona Statutes, in the judgment of my therapist, as deemed necessary.

I understand and agree that Fit Family Physical Therapy, LLC provides in-home physical therapy treatment for my convenience. I hereby consent to allow Fit Family Physical Therapy, LLC and its employees or staff to come into my home and provide such physical therapy services for my child.

Release of medical records:
I understand and agree that Fit Family Physical Therapy, LLC will maintain my child’s privacy to the highest standards and may ONLY use or disclose my child’s personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment involved in my medical care.

I agree that Fit Family Physical Therapy, LLC may obtain information from others who have provided medical care to my child and/or are responsible for the payment of all or part of my child’s bills when this information is needed in order to treat, bill, and/or receive payment.

I can request or access a copy of “FFPT - Notice of Privacy Practices” as mandated by HIPAA. A printed copy is available upon request to Fit Family Physical Therapy, or I may access directly on their website at www.fitfamilypt.com.

Fit Family Physical Therapy, LLC
Phone: (480)788-0046
Fax: (480) 771-3415

I authorize the release of my child's medical records to my physicians/primary care provider, other medical providers, or insurance companies as needed.

Notification of HIPAA
I acknowledge that I have received or been offered a copy of Fit Family Physical Therapy, LLC's Notice of Privacy Practice, which describes how my child's PHI is used and shared. I understand that Fit Family Physical Therapy, LLC has the right to change this notice at any time. I may obtain a current copy by contacting Fit Family Physical Therapy, LLC. My signature below acknowledges that I have been offered a copy or provided access to a copy of the Notice of Privacy Practice.

I have read the above information, and I consent to physical therapy evaluation and treatment for my child or dependent. By signing below, I acknowledge that I have read, understood, and will abide by the conditions and policies noted on this consent form.

Parent/Guardian Signature: _____ Date: _____

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Payment/Financial Policy Statement

Thank you for choosing Fit Family Physical Therapy, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand, and agree to the following payment policies.

- You agree to be financially responsible for all charges, regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

- Payment is expected at time of service unless you have made other payment arrangements with us.

- **Out-of-Network Policy**. We are out of network with your health plan. If you have out-of-network benefits, we will provide you with a copy of your bill upon request that you can submit to your health plan carrier for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and to obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

- **Medicare/Medicaid Policy**: If your child/dependent is one of these beneficiaries, you understand that our licensed physical therapists are not enrolled as a provider for any of these policies. They have onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since our services do not meet these covered benefit requirements, and we are not enrolled providers, our services will not be covered (paid) in full or in part by these policies (including Medicare Advantage Plans), even if the same services might be considered covered benefits when provided by another enrolled provider. We will not submit claims on your behalf or provide you with a statement or invoice. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from an enrolled provider. By choosing to receive our services after being fully informed of these facts, you are agreeing to pay privately for the services you receive from us, even if those services may be covered by another enrolled provider. You also understand that since we are not enrolled providers and our services do not meet the technical requirements for covered benefits, our services are not subject to maximum allowable charge. **You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, or statements to these policies for reimbursement or to obtain a denial for any policy supplemental insurance plan**.

- **Medicare as a Secondary Payer**. If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we are not Medicare/Tricare/Medicaid enrolled providers, they will not pay your copays, co-insurance, or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to these policies.

- **Privacy Rights**. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare/Medicaid, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy. We will not disclose your medical records to any third party, including your health insurance carrier, unless you sign our Authorization to Release Protected Health Information form to disclose your health information.

- **Appeals Policy**. You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal, contact the consumer assistance agency on your denial letter.

I have read, understand, and agree to these payment terms.

Parent/Guardian Signature: _____ Date: _____

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Cancellation & No-Show Policy

If you need to cancel an appointment, you can do so via use of our PT Everywhere app, email, or by calling/texting our team at (480)788-0064 to cancel. Any appointments within 24 hours cannot be cancelled using the app and you will need to choose another method to inform us of the cancellation or request to reschedule.

Please be advised that cancellations made after 8AM on the day of the appointment will be subject to the full visit charge. This includes appointments where our provider is unable to access the property, is turned away, or the client is unavailable.

I understand the greatest benefit from therapy is with consistent attendance and participation in the plan of care. I understand that if I cancel prior to 8AM on the day of an appointment with Fit Family Physical Therapy, I will not be charged. I understand that **if I cancel after 8AM on the day of the appointment or fail to be present (no-show) for a scheduled appointment, I will pay a cancellation fee equal to the full visit charge.**

Appointments may be cancelled by phone, text, email, use of PT Everywhere app, or in person.

Parent/Guardian Signature: _____ Date: _____

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Media Permissions

Please initial by one of the following statements.

_____ I **DO** grant permission to Fit Family Physical Therapy, LLC to use my child's image (photographs and/or video and written reviews) for use in media publications including: videos, print marketing, newsletters, general publications, website, and social media platforms.

I waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ I **DO NOT** grant permission to Fit Family Physical Therapy, LLC, to use my child's image (photographs and/or video and written reviews) for use in media publications including: videos, print marketing, newsletters, general publications, website, and social media platforms.

Parent/Guardian Signature: _____ Date: _____

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Fit Family
PHYSICAL THERAPY

COVID-19 Assumption of Risk and Waiver of Liability

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact, and/or by contact with contaminated surfaces and objects, as well as in the air. People reportedly can be infected and show no symptoms, and therefore, spread the disease. The exact methods of spread and contraction are unknown, and there is no known treatment or cure. A vaccine for COVID-19 is available but doesn't guarantee that it will not be contracted. Additionally, children <12Y of age have not been recommended or granted use of this vaccine as of yet. Evidence has shown that COVID-19 can cause serious and potentially life-threatening illness and even death.

Fit Family Physical Therapy, LLC has put preventative measures in place to reduce the spread of COVID-19. However, Fit Family Physical Therapy, LLC cannot guarantee that you will not become exposed to, contract, or spread COVID-19, while attending a physical therapy appointment. Therefore, if you choose to attend a Fit Family Physical Therapy, LLC physical therapy appointment, you may be exposing yourself and/or family members and/or increase your risk of contracting or spreading COVID-19.

Assumption of Risk: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself and my child/dependent in order to attend a Fit Family Physical Therapy physical therapy appointment. These services are of such value to me and my child, that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to attend a Fit Family Physical Therapy, physical therapy appointment. If I or my child test positive for COVID-19 within two weeks of attending a Fit Family Physical Therapy, LLC physical therapy appointment, I will notify Fit Family Physical Therapy who will notify the group that they had a potential exposure.

Waiver of Lawsuit/Liability: I hereby forever release and waive my right to bring suit against Fit Family Physical Therapy, LLC, and its owners, officers, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to attending a Fit Family Physical Therapy, LLC physical therapy appointment. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

Mask Policy: At this time, any employee of Fit Family Physical Therapy, LLC will wear a mask. You are entitled to your own decision making of wearing a mask or not. We appreciate your understanding during this time.

I have carefully read and fully understand all provisions of this release and freely and knowingly assume the risk and waive my rights concerning liability as described above.

Parent/Guardian Signature: _____ Date: _____

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Communication Policies

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Fit Family Physical Therapy, LLC respects your right to confidential communications about your child or dependent's protected health information (PHI), as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text, you are consenting to email and texting communications that may not be encrypted. Voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your child or dependent's protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. Fit Family Physical Therapy, LLC will not be responsible for any privacy or security breaches that may occur through voice or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit the risk of exposing your child's protected health information to unauthorized persons.

Please check one of the following choices:

- ☐ I **DO** consent to all communication, including but not limited to, communication about my child's medical condition and advice from my child's health care providers by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail

- ☐ I **DO NOT** consent to any voicemail, email or texting communication.

Email address you are consenting to use for communication: _____

Phone number you are consenting to use for communication: _____

Printed Patient/Child Name: _____

Printed Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

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