CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by physical therapists employed by or under contract with the Joy of Therapy, PLLC. The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment. The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment. The physical therapist has also explained that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand that the practice of physical therapy is not an exact science and that reputable practitioners cannot guarantee results. I acknowledge that no guarantees have been made by anyone regarding the outcome of the physical therapy treatment that I have requested and authorized.

I am aware that in the State of Florida, I may be treated by a physical therapist for 30 days without a physician's prescription. Furthermore, I understand that it is my responsibility to obtain a physician's prescription if treatment exceeds 30 days in order to continue said treatment.

I confirm that I have read and fully understand this consent form:

_____ _____

Printed Name (Parent/Guardian if under 18) **Signature** **Date**

For the physical therapist:
I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed evaluation and treatment and have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____ _____

Physical Therapist **Date**

PHOTO/MEDIA RELEASE

I, _____, consent and authorize the Joy of Therapy, PLLC, located at 1809 Miccosukee Commons Drive #114 Tallahassee, FL 32308, to have my photograph taken for the purpose of evaluation, treatment and as a part of my medical record.

☐ I do authorize Joy of Therapy PLLC to use my likeness in any photograph, video or other digital media in any and all of it's publications, including print and/or web-based publications and social media. I irrevocably authorize the Joy of Therapy PLLC, to copy, edit, enhance crop or otherwise alter any photo, video or other digital media. I also waive any rights for approval or inspection of any photos, videos or digital media.

☐ I do NOT authorize Joy of Therapy PLLC to use my likeness in any photograph, video or other digital media in any and all of it's publications, including print and/or web-based publications and social media.

I acknowledge that I am not entitled to any compensation or royalties with respect to the use of the photos, videos or digital media or likeness. I have carefully read and fully understand all the provisions of this Photo/Media Release Form and am freely, knowingly and voluntarily signing. I confirm that I have read and fully understand this consent form:

_____ _____

Printed Name **Date**

_____ _____

Signature **Date**

_____ _____

Parent/Guardian if under 18 **Date**

HIPAA PATIENT RIGHTS

Name:_____ DOB:_____

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Joy of Therapy, PLLC or disclosed to others for the purpose of treatment, obtaining payment, supporting the day-to-day health care operations of the practice, and for appointment reminders.

Name of Individuals involved in your care to whom we may disclose information:

Name: _____
Relationship:_____
Name: _____
Relationship:_____

Notice of Privacy Practices

The Notice of Privacy Practices is available on our website and in our clinic and you are encouraged to review the practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this form.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request in writing a restriction on the use or disclosure of your protected health information. Joy of Therapy, PLLC may or may not agree to restrict the use or disclosure of your protected health information. If Joy of Therapy, PLLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. And use or disclosure that has already occurred prior to the date on which our revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Joy of Therapy, PLLC reserves the right to modify the privacy practices outlined in this notice.

Signature

I have reviewed this consent form and acknowledge that I have been given the opportunity to review the Joy of Therapy, PLLC Notice of Privacy Practices. I give my permission to Joy of Therapy, PLLC to use and disclose my health information in accordance with it. This consent expires one year from the date below.

_____ Date:_____

Patient Signature
(Parent/Guardian signature required if under18)

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PHYSICAL THERAPY

PATIENT REGISTRATION

Today's Date: _____

Patient Name: _____
Last First Middle

Birth Date: _____

Local Address: _____
Street City State Zip Code

Phone # (cell) _____ (home) _____

E-mail Address: _____

Primary Physician: _____

Office Phone: _____ Fax: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

MEDICARE ONLY

Responsible Party/Subscriber: _____
First Middle Last

Subscriber ID: _____ Subscriber Phone #: _____

Subscriber Date of Birth: _____ Subscriber Address: List below or check same as Patient ☐

_____

Body Part to be Treated _____

Date of Onset/Injury _____ Surgical Intervention _____ Date _____

Problem Description / Mechanism of Injury:

_____

_____

Prior Treatment for this problem:

_____

_____

What are your goals for therapy? _____

_____

JOY OF THERAPY
PHYSICAL THERAPY

MEDICAL HEALTH FORM

To ensure you receive a complete and thorough evaluation, please provide this important background information on the following form:

Last Name: _____ First Name: _____ Age: _____

Are you currently seeing any of the following? Please check all that apply.

- ☐ Medical Doctor (MD)
- ☐ Osteopath (DO)
- ☐ Physical Therapist/Occupational Therapist
- ☐ Psychiatrist/Psychologist
- ☐ Chiropractor
- ☐ Oral Surgeon

If you have seen any of the above during the past three months, please describe for what reason:

_____

_____

PERSONAL MEDICAL HISTORY:

Have you ever been diagnosed as having any of the following conditions? Please check all that apply:

- ☐ Anemia
- ☐ Asthma
- ☐ Cancer:
  Describe what kind: _____
- ☐ Chemical Dependency (i.e., alcoholism, drugs)
- ☐ Circulation problems
- ☐ Depression
- ☐ Diabetes (type I or II)
- ☐ Emphysema/Bronchitis
- ☐ Epilepsy
- ☐ Gout
- ☐ Headaches or Dizziness
- ☐ Heart Condition/Angina
- ☐ Hepatitis (type)_____
- ☐ High/Low blood pressure
- ☐ Kidney Problems
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Currently pregnant
- ☐ Number of pregnancies _____
- ☐ Other Arthritis conditions
- ☐ Pacemaker
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Unusual reaction to heat/cold
- ☐ Visual/Hearing difficulties

SURGERIES or other conditions for which you have been hospitalized for, including the approximate date and reason for the surgery or hospitalization in the past 10 years.

List the date, surgery/hospitalization and reason: _____

_____

INJURIES for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury in the past 10 years:

List the injury and date: _____

_____

PRESCRIPTION medications you are currently taking (including pills, injections, and/or skin patches):

List the drug name, frequency and dosage: _____

_____

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PHYSICAL THERAPY

ALLERGIES or reactions to medications, food, plants or insect bites: _____

_____

Please indicate your level of activity: Sedentary Active Athletic

0 1 2 3 4 5 6 7 8 9 10

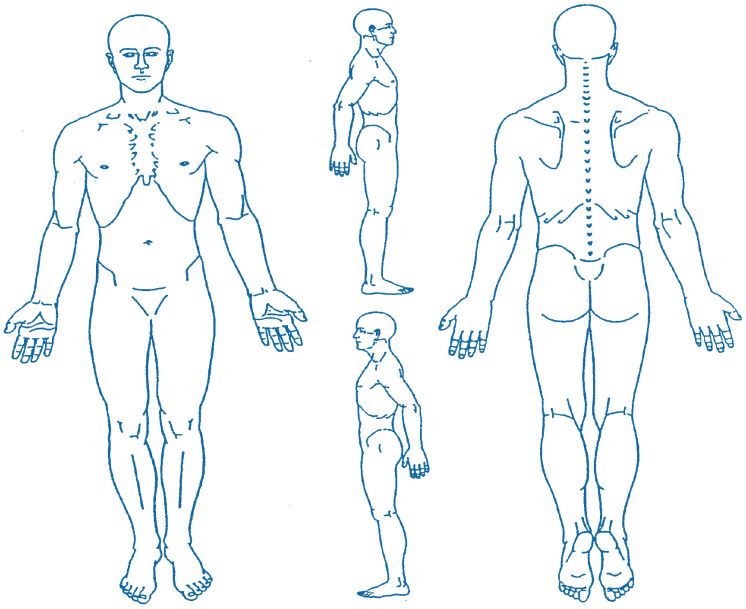
Is your injury keeping you from doing your normal or recreational activities? Yes No

If yes, please list the activities:_____

CHANGES IN THE PAST MONTH: Check all that apply.

☐	Depressed	☐	Difficulty falling asleep	☐	Falls
☐	Fatigue	☐	Fever/chills/sweats	☐	Numbness or tingling
☐	Nausea/Vomiting	☐	Weakness	☐	Weight loss/Gain

PLEASE FILL IN THE FIGURES WHERE YOUR PAIN IS.
Shade in areas of pain.



Circle the number that describes the intensity of your pain:

At best 0 1 2 3 4 5 6 7 8 9 10
(0= none, 5= moderate , 10 = severe)

At worst 0 1 2 3 4 5 6 7 8 9 10
(0= none, 5= moderate , 10 = severe)

Have you suffered a low back or neck injury in the last 10 years: YES__ NO__

If yes, what level was injured and what was your diagnosis? _____

Have you had surgery to the back and/or neck? YES__ NO__

Are you still having low back or neck symptoms? YES__ NO__

Do you feel that your current arm, hand, leg or foot symptoms have any connections with your back/neck pain? YES__ NO__

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FINANCIAL AGREEMENT

Financial Agreement, Guarantee of Account

I, the undersigned, agree whether I sign as a parent, guardian, spouse, agent, guarantor or as a patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of Joy of Therapy PLLC, in accordance with the regular rates and terms of Joy of Therapy PLLC. I understand that I have up to 30 days to pay invoices, and then a late fee of $15 will be added for each additional 30 days that my account is delinquent. I understand that physical therapy services are rendered and charged to the patient and not to the insurance company, and the clinic cannot accept total responsibility for collection of claims nor for negotiating a disputed settlement. I agree to be responsible for full payment at the time of services rendered. Should the account be referred to an agency or attorney for collection, I shall pay the actual attorney's fees and collection expenses.

Medicare Patient Certification

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediate or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

I further understand that the Joy of Therapy PLLC will submit my claims to Medicare on my behalf. If a claim is denied payment and all effort has been made by the clinic to satisfy Medicare's requirements, then it is my responsibility to pay any unpaid claims. I also understand the Joy of Therapy PLLC will not bill my supplementary insurance company as these insurance companies are not under contract with the Joy of Therapy PLLC. The Joy of Therapy PLLC will provide me with a superbill so that I may then submit the claim to my supplementary insurance policy.

This form has been fully explained to me, and I certify that I understand its contents and accept its terms.

Signature of Patient OR Patient Representative | **Relationship to Patient**

Printed name of Patient or Patient Representative | **Date**

CANCELLATION POLICY

In an effort to meet the needs of all of our clients, and to be able to schedule needed sessions, we have instituted a cancellation policy. ***Think of this as our commitment to get you the results you want in your health.***

1. There will be a **$25 fee for appointments not cancelled at least 12 hours before your appointment.** We reserve the right in our sole discretion to make exceptions for true emergencies. You are welcome to leave a voicemail at 850-765-0213 and/or email at info@joyoftherapypt.com

2. If you do not cancel and do not come to your scheduled appointment without notifying the clinic in advance, the **No-Show Fee of $50** will be billed to you via mail and email.

Thank you for respecting our time and all of our clients' time.

I have read and understand the cancellation policy.

Signature of Patient OR Patient Representative | **Relationship to Patient**

Printed name of Patient or Patient Representative | **Date**

JOY OF THERAPY
PHYSICAL THERAPY

Consent for Health Information to be Communicated by Electronic Means

Patient Name: _____

Parent Names: _____

Phone: _____

Address: _____

City/State/Zip: _____

By signing below, I expressly permit Joy of Therapy, at its discretion, to communicate personal health information for the above named patient, via e-mail, phone, and electronic messaging.

Phone Number: _____

E-mail: _____

1. E-mail and electronic messaging risks and your responsibility

At the discretion of Joy of Therapy, its employees and staff, and upon your agreement to the terms herein, Joy of Therapy may use e-mail and electronic messaging to correspond with you. These e-mails and electronic messages may contain your or your child's personal health information. If you agree to allow Joy of Therapy to communicate with you via e-mail and electronic messaging, you should be aware of the following risks and your responsibilities:

a) Due to the fact that the internet is not inherently secure or private, unauthorized people may be able to intercept, read and possibly modify e-mails you send or are sent by Joy of Therapy.

b) You must protect your e-mail account, password and computer against access by unauthorized people. It is suggested that you install and maintain virus protection software on your personal computer.

2. Conditions for the use of e-mail and electronic messaging

By consenting to the use of e-mail and electronic messaging with Joy of Therapy, you agree that:

a) Joy of Therapy may forward e-mails as appropriate for diagnosis, treatment, scheduling, reimbursement, billing and other related reasons. As such, Joy of Therapy employees and contractors, other than the recipient, may have access to e-mails and electronic messages that you send.

Joy of Therapy will not forward e-mails or electronic messages to independent third parties without your prior written consent, except as authorized or required by law.

b) Although Joy of Therapy will use its best efforts to read and respond promptly to your emails, Joy of Therapy staff may not read your e-mail immediately. You should not use email to communicate with Joy of Therapy in the event of an emergency you require a response to in a short period of time.

c) If your e-mail asks for a response and you have not heard from Joy of Therapy within a reasonable period of time, **please follow up directly with our office**.

d) You should carefully consider the use of e-mail and electronic messaging for the communication of any sensitive medical information.

e) You are responsible for updating your e-mail address and phone number with our office in the event of any changes.

f) Joy of Therapy reserves the right to save your e-mail and include your e-mail or information contained in your e-mail in your/your child's medical records.

g) Joy of Therapy reserves the right to cease e-mail communication with you at any time, at its discretion.

3. Acknowledgement and Agreement

Joy of Therapy will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, Joy of Therapy cannot guarantee that all e-mail and electronic messaging will be confidential. Additionally, Joy of Therapy will not be liable in the event that you or anyone else inappropriately uses or accesses your email or electronic messages. Joy of Therapy will not be liable for improper disclosure of your or your child's health information that is not caused by Joy of Therapy's intentional misconduct.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail and electronic messaging between myself and Joy of Therapy, and consent to the conditions outlined herein. I understand that this consent is valid until such time as I revoke the consent in writing.

Patient OR Parent/ Legal Guardian Signature Date