DOCTOR OF PHYSICAL THERAPY, LLC

Demographics and Consent to Treat

Patient Name: _____ Date of Birth: ___/___/___
First - Middle Initial - Last Month/Day/Year

Address: _____

Patient's Preferred Name: _____If under 18 years old; Guardian's Name: _____

Emergency Contact/Phone number/Relationship: _____

Referring Physician Contact/Phone number/Address: _____

Primary Care Physician Contact/Phone number/Address: _____

For your optimal bone and joint safety, I recommend not having another provider such as another physical therapist, chiropractor, personal trainer, coach, or other provider; video, online advice that gives/provides/ suggests exercise or movements while under the care of this PT. Should you decide on another provider, please know there are no hard feelings but I will not see you until your care is discharged with that provider. With that said, I encourage an open dialogue with questions/concerns re: other providers and/or approaches.

Consent to Evaluation and Treatment I consent to receive treatment from A.D.M. Doctor of Physical Therapy, LLC **.** I do hereby consent to such treatment by the authorized licensed personnel of A.D.M. Doctor of Physical Therapy, LLC as may be dictated by prudent medical practice by my condition. Thank you for allowing us the opportunity to serve you. If you have any questions about the enclosed information, please ask for assistance. Kindly sign and date this form to indicate that you understand and agree to the terms of the consent to treat.

I acknowledge I am responsible for payment at the time services are rendered. Payment is due at the time the services are rendered. Cash, check and credit cards are accepted, at this time. Should patient prefer to pay by credit card, patient will be responsible for the charge incurred by Square credit card processing: 2.6% plus 10 cents per transaction. Please note, this fee goes directly to the Square platform and not for profit of A.D.M. Should a check be returned by the bank, patient is responsible for the return check charge in addition to the balance owed. You will remain financially responsible for the services rendered, regardless of the payment option. In the event your account becomes delinquent and in default of payment, the patient or legal guardian will be responsible for the principal amount owed and all reasonable costs associated with the recovery of this debt.

Patient/Legal Representative Printed Name: _____

Patient/Legal Representative Signature/Date: _____

Last updated: 11/24/2024

A.D.M. Doctor of Physical Therapy, LLC – Mobile Tele: 239-944-6318 – Email Address: Anthony@ConciergePTatHome.com
Mailing Address: PO Box 884, Marco Island, Florida 34146

DOCTOR OF PHYSICAL THERAPY, LLC

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL DUTY: A.D.M. Doctor of Physical Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION: A.D.M. Doctor of Physical Therapy, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your PHI to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest for you.

A.D.M. Doctor of Physical Therapy, LLC may also use or disclose your PHI without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain written authorization before disclosing your PHI. If you provide us written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

A.D.M. Doctor of Physical Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Privacy Practices will be provided to you next visit. You may also request a copy of the Notice at any time.

PATIENT'S INDIVIDUAL RIGHTS: You have the right to review or obtain a copy of your PHI at any time. You have the right to review or obtain a copy of your PHI at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances that we have disclosed your PHI for reasons other than treatment, payment, or other related administrative purposes. You may also request in writing that we not use or disclose your PHI for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances.

CONCERNS AND COMPLAINTS: If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your PHI, please contact our practice manager, or send a written complaint to the US Department of Health and Human Services. **OCRComplaint@hhs.gov**

WAIVER OF RIGHT TO LITIGATE: The parties acknowledge that they have a right to litigate claims through a court before a judge or jury but will not have that right if any party elects arbitration pursuant to this arbitration provision. The parties hereby knowingly and voluntarily waive their rights to litigate such claims in court before a judge or jury upon election of arbitration by any party.

I understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

A copy of the Notice of Privacy Practices was reviewed, and I have a copy for my records.

Signature and Date: _____

Relationship to patient if signed by a representative of the patient: _____

Last updated: 02/07/2023

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