Professional Physical Therapy Consent

Clarification Text

Physical therapy is a healthcare specialty focused on the evaluation, diagnosis, and treatment of conditions that limit an individual's ability to move and function in their daily life. Physical therapists use a combination of hands-on techniques, virtual(online) evaluations/assessment/treatment, exercises, and modalities to help alleviate pain, improve mobility, and restore function.

It is important to note that physical therapy is not a one-size-fits-all approach and each patient's treatment is individualized to their specific needs and goals. Physical therapists work closely with patients to develop a plan of care that takes into consideration their medical history, current symptoms, and functional limitations. Response to physical therapy intervention varies from person to person; hence it is not possible to accurately predict your response to a specific procedure, exercise protocol or modality. Our physical therapist does not guarantee what your reaction will be to a specific treatment, nor does she/he guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns.

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 virtual and/or in-person examination results.

Consequently, it is your right to discuss the potential risks and benefits involved in your treatment. If you have any questions or concerns about physical therapy, it is recommended that you discuss them with your physical therapist and healthcare provider.

Consent Form

I hereby consent to receive physical therapy treatment virtually and/or in-person from Firstline lymph and pelvic therapy LLC.

I understand that physical therapy is a treatment for various conditions, including but not limited to, pain, weakness, and limited mobility. Physical therapy may involve manual therapy, exercises, home program/home exercises, modalities, treatment tools and other treatment deemed necessary by my physical therapist.

I acknowledge that virtual physical therapy (Tele-physical therapy) has limitations in examining patients, and it is my due diligence to have myself examined and assessed by a physician, prior to or after virtual/tele-physical therapy.

I acknowledge that it is my responsibility that I am in a safe and private environment while receiving concierge and/or virtual/tele-physical therapy.

I acknowledge that physical therapy may cause temporary discomfort or soreness and I assume the risks associated with physical therapy treatment. I understand that I am responsible for communicating any discomfort or pain to my physical therapy.

I hereby authorize Firstline lymph and pelvic therapy LLC to release any information regarding my physical therapy treatment to my physician(s) and/or other healthcare providers as deemed necessary.

I acknowledge that I have the right to refuse treatment and to discontinue physical therapy at any time.

It is my right to be chaperoned or to decline to be chaperoned during any assessment/treament. I acknowledge that a chaperone is not provided by the Firstline Lymph and Pelvic Therapy LLC, and I should come with my caregiver/family member if I wish to be chaperoned. If not, Firstline Lymph and Pelvic Therapy LLC will assume that I declined to be chaperoned.

I acknowledge that Tele-physical therapy is conducted via 2 way audio visual technology and I am or will be in the states of Maryland at the time of the visit(s).
I acknowledge that the grace time for tele- physical therapy visit is 10 min, and therapists will mark my appointment as “No Show”. In the case of “No show”, I agree to pay full charge for the visit.

I acknowledge that I need to change or cancel an appointment at least 24 hours prior to my appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a full charge.

I consent to the therapy terms and conditions above, as well as the Financial Responsibility Agreement.

I acknowledge that I have been informed of my rights as a patient receiving physical therapy and have had the opportunity to ask questions and receive answers to my satisfaction.

Patient’s Full name (In print): _____

Legal guardian’s Full name (In print): _____
Relationship to the patient: _____

Patient/ legal guardian’s Signature : _____x

Date: _____

WAIVER AND RELEASE OF LIABILITY

IN CONSIDERATION OF the risk of injury that exsits while participating in TELE-PHYSICAL THERAPY and IN PERSON PHYSICAL THERAPY (hereinafter the “Activity”); and

IN CONSIDERATION OF my desire to participate in said Activity and being given the right to participate in same;

I HEREBY, for myself, my heirs, executors, administrators, assigns, or personal representatives (hereinafter collectively, “Releaser”), knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Activity, and do hereby release and forever discharge Firstline lymph and pelvic therapy LLC, in Maryland USA, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an event related to this Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES AMY ARISE FROM MY OWN OR OTHERS’ NEGLIGENCE, CONDITIONS RELATED TO TRAVEL, OR THE CONDITION OF THE ACTIVITY LOCATION(S), OR MY OWN NEGLIGENCE OF NOT BEING EXAMINED BY A PHYSICIAN PRIOR TO MY PARTICIPATION IN THE AFOREMENTIONED ACTIVITY. NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY.

I agree to indemnify and hold harmless Firstline lymph and pelvic therapy LLC against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney’s fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If Firstline lymph and pelvic therapy LLC incurs any of these types of expenses, I agree to reimburse Firstline lymph and pelvic therapy LLC.

I acknowledge that Firstline lymph and pelvic therapy LLC and their directors, officers, volunteers, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Firstline lymph and pelvic therapy LLC.

I ACKNOWLEDGE THAT THIS ACTIVITY MAY INVOLVE A TEST OF A PERSON'S PHYSICAL AND MENTAL LIMITS IN PERSON AND/OR VIRTUALLY, AND MAY CARRY WITH IT THE POTENTIAL FOR DEATH, SERIOUS INJURY, AND PROPERTY LOSS. The risks may include, but not limited to, those caused by terrain, facilities, temperature, weather, lack of hydration, condition of participants, equipment, vehicular traffic and actions of others, including but not limited to, participants, volunteers, spectators, coaches, event officials and event monitors, and/or producers of the event.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE FIRSTLINE LYMPH AND PELVIC THERAPY LLC AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST FIRSTLINE LYMPH AND PELVIC THERAPY LLC FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of Firstline lymph and pelvic therapy LLC, its agents, and employees.
In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

Patient's Full name (In print): _____

Legal guardian's Full name (In print): _____
Relationship to the patient: _____

Patient/ legal guardian's Signature : _____ x

Date: _____

HIPAA & Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

WE CONSIDER THE PRIVACY OF YOUR HEALTH INFORMATION OF PARAMOUNT IMPORTANCE.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, our healthcare operations, when suspecting abuse and/or neglect, when required by law, and for appointment reminders.

Your Authorization: In addition to our use of your health information for treatment, payment, health care operations, or when required by law, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally disclose your health information for any reason except those described in this Notice.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request copies in a format other than photocopies. Please note that the 1st

copy is free of charge. However you will be charged $10 from the 2nd copy. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

We support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

*By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices

Patient's Full name (In print): _____

Address:_____
_____

City:_____ State: _____ ZipCode: _____

Legal guardian's Full name (In print): _____
Relationship to the patient: _____

Patient/ legal guardian's Signature : _____ x

Date: _____

General questionnaire

1. What is your occupation? _____

2. Do you exercise regularly? Y / N

3. How woul you rate your overall health? Excellent / Good / Fair / Poor

4. Please check off if you have had any of the conditions listed below:
   _____ High blood pressure
   _____ Epilepsy
   _____ Angina
   _____ Diabetes
   _____ Heart attack
   _____ Rheumatoid Arthritis
   _____ Stroke
   _____ Arthritis
   _____ Asthma
   _____ Pregnancy
   _____ HIV/AIDS
   _____ Other

   _____ Tumor
   _____ Tobacco packs/day ____
   _____ Systemic Lupus
   _____ Drug or Alcohol Dependence
   _____ Hepatitis
   _____ Coffee/Tea/Caffeine drinks: cups/cans per day ____
   _____ Cancer Location: Date: ___/___/___ Present:

5. BMI:

   Weight _____ lbs
   Height: Feet_____ Inches _____

6. Hospitalization/Surgical Procedures (list if not described elsewhere):

   _____
   _____
   _____

   Medications:

   _____
   _____