Peregrine PT
PHYSICAL THERAPY

CONSENT TO PHYSICAL THERAPY

Adult patients have the basic right to make their own health care decisions. Patients who are minors or who are not competent to make medical decisions have the right to have their parent or legal representative make medical decisions on their behalf. To exercise this right, a patient is entitled to the information necessary to make an informed decision whether to consent or to refuse treatment. By signing this form, I acknowledge that, with respect to services rendered by Romy Havard, PT, DPT, OCS and/or Peregrine Physical Therapy, and their employees and agents (collectively "Provider"), I understand the following.

1. Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Provider will refer you to a physician surgeon (or to a person licensed to practice dentistry, podiatric medicine, or chiropractic) if at any time, you have signs or symptoms of a condition that requires treatment beyond the scope of Provider's practice or if you are not progressing toward documented treatment goals as s demonstrated by objective, measurable, or functional improvement.
Provider has given adequate, intelligible information about the proposed physical therapy, including a clear explanation of the risks, benefits, and alternatives to physical therapy treatment.

2. Benefits of Provider's Approach and Scope of Practice

I understand that Provider uses diagnostic and treatment methods within her scope of practice as a licensed physical therapist. Physical therapy ("PT") improves mobility and motion, reduces pain, reduces risk of injury, improves balance and reduces fall risk, rehabilitates movement after injury or disease, helps to manage chronic illnesses, reduce need for medications, and helps prevent surgery. Therapists train caregivers to improve safety and efficiency during caregiving tasks. PT has also been shown to help improve mood and psychological conditions, improve sleep, and improve overall quality of life.

3. Risks

The primary risks of physical therapy include side effects of exercise, such as risk of increased fatigue, muscle soreness or strain, swelling, pain, aggravation of injury, risk of fall, and lack of progress toward goals. There is a risk of skin irritation with use of thermal modalities, topical lotions, and tape adhesives. As with any physical activity, there is a small risk of death. I understand that, notwithstanding the risks set forth herein, Provider only employs treatments she believes to be safe and effective.

4. Alternatives

As alternatives, Provider encourages me to speak with and consider the advice of other clinicians regarding my overall care. Patients who do not wish to pursue physical therapy can discuss medical, pharmacological, or surgical alternatives with their physician. Alternatives to specific modalities can be discussed with the PT.

5. General
No Claims or Guarantees: I am responsible to disclose to Provider all medication, care, treatment, diagnoses, and assessments that I receive elsewhere and to provide medical records from other providers to ensure that care is coordinated and compatible. I understand that Provider makes no representations, claims or guarantees that my medical problems or conditions will be cured, solved, or helped by undergoing treatment by Provider.

Referrals: I understand that Provider's treatment may include recommendation that I seek other types of treatment from other health professionals who are not affiliated with Provider. I understand that Provider does not supervise these professionals and is not responsible for them. I understand that they are not Provider's employees and that they will bill separately for their services.

Ancillary Products: From time to time, Provider may make available products for sale to her patients. To the extent there is a usual and customary markup on these products, Provider has a financial interest in sales of these products. I understand that I am not obligated to purchase these products, and can purchase products from any source of my choosing. I understand that the health care services I am offered will not be affected if I choose to purchase similar products elsewhere. I understand that while Provider may recommend products, Provider is not responsible for results from using those products, and makes no warranties or claims regarding use of the same.

Follow-Up Care: I understand that Provider may follow up with me by phone or online while I am traveling in other states or between visits.

6. Assumption of Risk; Indemnity. I knowingly, voluntarily, and intelligently decide to receive the services described above, and I knowingly, voluntarily, and intelligently assume all risks involved in the same. As a result of my assumption of these risks, I agree to release, hold harmless, indemnify, and defend Provider from and against any and all claims which I (or my representatives) may have for any loss, damage, or injury arising out of or in connection with use of the services described above, or arising out of or in connection with referral to other practitioners or merchants for delivery of any services. As a result, I agree not to pursue a claim against Provider, simply because I am dissatisfied with the results of the above services.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.
I have carefully read this form and acknowledge that I understand it. I have had opportunities to ask questions, and accept and agree to all of the terms above. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. If any portion of this form is held invalid, the rest of the document will continue in full force and effect.

X______________________________________. Date: ___________________

Signature of Patient and/or Guardian

Relationship of Guardian:______________________________

Peregrine PT
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Patient Intake

Name:	Date of Birth:
Phone (mobile):	Phone (alternate):
Email:	
Home Address:	
Gender assigned at birth: (circle) M, F	Pronoun: (circle): M, F, TF, TM, They, NB, Other
Employer:	
Occupation:	
Supervising MD, DO, Pa, or NP: -name: -address: -phone number: -fax number:	
Emergency Contact, Phone Number, and Relationship:	
Medical Insurance Carrier:	
How did you hear about Peregrine PT?	
Current Health Concerns/Co-morbidities:	
Current Medications:	
Surgeries/Procedures:	

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Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email 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 your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

I do not consent to any voicemail, email or texting communication.

I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all that you consent to)

- Email
- Text
- Voicemail

I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent to)

- Email
- Text
- Voicemail

E-mail address: ____

Phone number: ____

Patient Signature: ____ Date________________

Parent/Guardian Signature:________________________________ Date________________

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Payment Agreement and HIPAA Acknowledgement

Thank you for choosing Peregrine Physical Therapy, Inc. 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 the time of service unless you make other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, 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. You are responsible for contacting your insurance company to determine what your benefits are and 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.
- Patients are responsible for the copy charges for full medical records when requested from patients, insurance companies, and other doctor's offices. Copy charges are $25.00 for small records and $50.00 for large records.
- **Cancellation Policy**. If an appointment cannot be kept, or less than 24 hours notice is given, there is a $50 charge.
- **Repeated Missed Appointment Policy.** If a patient misses 3 appointments, Peregrine Physical Therapy reserves the right to cancel all future appointments.
- **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has 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 and many of the services we offer are not covered by Medicare. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.
    - **Medicare Advantage Plans and Medicare Replacement Plans.** We are not in-network with any Medicare Advantage or Replacement Plans. If your Medicare Advantage or Replacement Plan offers

out-of-network benefits for services received from providers not enrolled with Medicare and we don't have to directly submit your claims, 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, you should be prepared that your health plan may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your health plan to determine what your benefits are and 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 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 commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare 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 Medicare.

- **Wellness & Fitness Services.** Most commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other visits.
  - **Use of Health Savings Accounts (HSA).** If you purchase a pre-paid package plan through your HSA account we will give you a receipt for the pre-paid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.
  - **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.
- **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, if you pay privately for your services at the time of service. If you pay 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 or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will 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 with your health plan, contact the consumer assistance agency on your denial letter.
- **Late Payment Penalty.** Unless prohibited by applicable law, a late payment penalty in the amount of 0.5% per month (6% per year) may be added to your bill for any and all claims that are not paid within thirty (30) days of the invoice or statement date. You agree to be personally responsible for paying this late payment penalty.
- **Collection Policy.** You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.
- **Service Termination Policy.** If we determine at any time that conditions in your home create a potentially unsafe environment for our providers, we may, at our sole discretion, terminate our services with you. If we do so, we will make reasonable efforts to refer you to the services you need to resolve the issue that is causing a potentially unsafe environment. If you have prepaid for any services, we will refund any monies paid for services not yet received as of the date or our termination.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Peregrine Physical Therapy, Inc. and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Peregrine Physical Therapy, Inc. and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

X ____ Date: ___________________________

Signature of Patient and/or Guardian

X____ Date: ___________________________

Signature of Provider Representative

HIPAA Acknowledgement

Please read the Notice of Privacy Practices posted on the website for Peregrine Physical Therapy and sign the acknowledgement below.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of Peregrine Physical Therapy Notice of Privacy Practices.

X____Date:___________________

Signature of Patient and/or Guardian

A photocopy of this agreement is to be considered valid, the same as if it was the original.

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Pelvic Floor Examination Consent Form (if internal exam/treatments are necessary)

I consent to receive treatment from a physical therapist with appropriate training to assess my pelvic floor through internal palpitation (vaginal and/or rectal exam).

I understand that I will have the opportunity to give/revoke my consent at each treatment session, and at any stage of the session.

I understand that I may have a person of my choice accompany me during the evaluation, and that the exam will occur in a clean, private & secure area.

I understand that I will be required to partially disrobe for the exam and that appropriate draping and coverings will be provided.

I will communicate relevant medical history information to the therapist including, but not limited to, medication use, IUDs (or other implants), pre-existing urogenital infection or known sexually communicable diseases.

I confirm that I am not in the first trimester of pregnancy (14 weeks).

I understand that this examination is performed by observing, palpating or inserting a gloved finger into the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and functional activity of the pelvic floor region.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, use of dilators, therapist conducted internal massage and trigger point release, use of self-administered internal massage, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort, an aggravation of my existing injury or minor bleeding. These effects are usually temporary; if they do not subside in 1-3 days, I agree to contact my therapist or physician.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I may experience improved continence. I should gain a greater knowledge about managing my condition and the resources available to me.

By signing below I acknowledge that I have read and understood the above information.

X____ Date: ___________________

Patient Signature