Patient/Client Information

Full Name:	Age:	Date of Birth:	☐ Female ☐ Male

Phone Number(s):	E-mail:

Address:	City, State, Zip:

Primary Care Physician (PCP) Name:	PCP Phone:

Have you consulted a physician regarding the current issue or injury? ☐ Yes ☐ No If yes ☐ My PCP ☐ Other provider(s)	*Do you have a referral from a physician for a specific treatment diagnosis?* ☐ Yes ☐ No

Emergency Contact Person:	Relationship	Phone:

We take pride in the high-level quality of our services. In order to provide you with the best possible care, please read the following policies and sign below to acknowledge our policies.

- Payment for services is due at the time services are rendered.
- Please honor a 24-hour cancellation policy.
- Wellness/Fitness services and packages are not coded physical therapy treatments, and may NOT be submitted to your insurance for reimbursement.
- Physical Therapist is an independent contractor, providing consultation services at this location.
- Physical Therapist will discuss your plan of care with you and make recommendations for a customized package or plan that may include a combination of private physical therapy treatments and wellness/fitness service (Pilates-based) and/or group wellness/fitness classes. The fee schedule may differ for the different types of services.
- Physical Therapist may make recommendations for additional medical care and/or transfer of physical therapy care to an outpatient clinic setting, if appropriate.
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If you have any questions about the above information, PLEASE don't hesitate to ask us. We are here to help you.

I have read and agree to all the policies mentioned above.

Printed Name:	Signature:	Date:

Consent for Services by a Physical Therapist

Informed Consent. The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that I will receive information from the physical therapist at the initial visit concerning the treatment and options available for my condition and to discuss my goals and plan of care.

Potential benefits. Benefits may include 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 should gain a greater knowledge about managing my condition and the resources available to me. Nevertheless, benefits are not guaranteed nor guaranteed to be permanent. I understand that the physical therapist does not provide a guarantee and that potential benefits may be temporary.

Potential Risks. I may experience an increase in my current level of pain or discomfort or an aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. I understand that it is my obligation to keep my physical therapist informed of my present condition and any unanticipated pain or discomfort as a result of physical therapy.

No warranty: My physical therapist will share with me his or her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. I understand that my physical therapist cannot and will not make any promises or guarantees regarding a cure for or improvement in my condition.

THE UNDERSIGNED ACKNOWLEDGES HAVING READ AND UNDERSTOOD THE ABOVE INFORMATION. THE UNDERSIGNED HEREBY CONSENTS TO PHYSICAL THERAPY EVALUATION AND TREATMENT BY PHYSICAL THERAPIST ***HEIDI FISHER, PT****.*

I, THE UNDERSIGNED, ALSO ACKNOWLEDGE THAT I WILL ABIDE BY THE CONDITIONS AND POLICIES NOTED ON THIS CONSENT FORM.

Printed Name:	Signature:	Date:

Privacy Policies and Patient Health Information Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Heidi Fisher, PT is required, by law, to maintain the privacy and confidentiality of your protected health information (PHI) and to provide her patients with notice of legal duties and privacy practices with respect to your PHI.

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other healthcare or fitness professionals involved you're your care for the purpose of treatment, payment or healthcare operations.

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Education: Heidi Fisher, PT is a clinical instructor and 2900 E. Broadway Blvd, Suite 138 is a teaching facility. As such, there periodically may be students observing your session or class. Please be assured that they are required to adhere to this published privacy policy.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement and Public Safety: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Heidi Fisher, PT is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Heidi Fisher, PT amend your protected health information. Please be advised, however, that Heidi Fisher, PT is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Heidi Fisher, PT.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Heidi Fisher, PT reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Heidi Fisher, PT is required by law to comply with this Notice.

Heidi Fisher, PT is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Heidi Fisher, PT by calling (520) 488-6715.

Complaints

Complaints about your Privacy rights, or how Heidi Fisher, PT has handled your health information should be directed to her by calling (520) 488-6715. If you are not satisfied with the manner in which this organization/entity handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of October 1st, 2014.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Heidi Fisher, PT with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice and I have received a copy or have access to an electronic copy of this form.

Printed Name:	Signature:	Date:

_____ _____
Authorized Facility Signature Date

Release of Liability & Informed Consent

I desire to engage voluntarily in Physical Therapy/Pilates/Wellness Program(s) with Heidi Fisher, PT. In order to attempt to improve my physical condition, I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory and musculoskeletal systems and, thereby, attempt to improve their function. The reaction of the cardiorespiratory and musculoskeletal systems cannot be predicted with complete accuracy. These changes might include abnormalities in blood pressure and heart rate, injury to the connective tissue and musculoskeletal systems potentially resulting in stroke, heart attack, permanent injury and possibly death.

The use of all facilities at 2900 East Broadway Blvd, Suite 138 in Tucson – exercise equipment including Pilates apparatus, props, weights – is undertaken by the patient/client at his/her sole risk. The risk of injury from activities involved in this program is significant, including the potential for permanent paralysis and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist.

Heidi Fisher, PT and Staff/Contractors are professionally licensed or certified in their respective fields. I understand that I am responsible for informing Heidi Fisher, PT or Representatives/Staff of any known physical limitations, illnesses, or other physical conditions. Should any unusual symptoms occur during my time at the above facilities, I will inform a Heidi Fisher, PT or representative/staff member immediately. In addition, if I experience a change in my physical limitations, illnesses or other physical conditions or become ill outside the facility I will inform a representative/staff member of this change prior to resuming treatment and/or workouts on my next visit and/or contact my doctor if the symptoms warrant. I have consulted my physician before participation in these programs and hereby represent to Heidi Fisher, PT that I have their approval to engage in such activities.

Heidi Fisher, PT is a clinical instructor and 2900 E. Broadway Blvd, Suite 138 is a teaching facility, and on occasion, there may be students observing patient/client sessions as it pertains to their educational requirements. There may also be interns and apprentice teachers assisting under the direct supervision of a qualified practitioner.

I willingly agree to comply with the stated and customary terms and conditions for participation. If, however I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of Heidi Fisher, PT or the nearest representative/staff member immediately.

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless Heidi Fisher, PT, their officers, officials, agents, independent contractors, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("Releasees"), with respect to all and any injury, disability, death, or loss or damage to person or property, whether arising from the negligence of the releasees or otherwise, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY/CONSENT FORM AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Printed Name:	Signature:	Date:

Please initial here_____ to indicate that you have received a copy of this consent form or have been informed as to where to find this form

FOR PARENTS/GUARDIANS OF PARTICIPANTS OF MINORITYAGE (UNDER AGE 18 AT TIME OF REGISTRATION)

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release, as provided above, of all the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, even if arising from their negligence, to the fullest extent permitted by law.

_____ _____

PARENT/GUARDIAN'S SIGNATURE DATE

EMERGENCY PHONE:_____