NOTICE AND ACKNOWLEDGEMENT FORM
OF
MOBILE PHYSIO LLC

The purpose of this Notice and Acknowledgement is to document that you have received, reviewed, and agree with the following policies and practices attached to this form (the "**Information Packet**"), which include:

1. Notice of Privacy Practices;
2. Financial Policy;
3. Consent for Treatment and Waiver of Liability; and
4. General Consent, Insurance, and Privacy Notice.

Please complete, sign, and date this form AFTER you have had a chance to review, understand, and/or ask questions about your rights to privacy and confidentiality, about physical therapy services, and about Mobile Physio's financial policy.

Patient Full Name: _____ (please print)

DOB: ____ / ____ / _____ (mm/dd/year)

I hereby acknowledge that I have received, reviewed, and agree with the Information Packet.

Patient Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

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**.**

I. Use and Disclosure of Protected Health Information:

Due to the nature of the services Mobile Physio provides to patients, we will collect personally identifiable information about you and your current and previous health conditions, receipt of health care, and/or the payment method for such health care ("Protected Health Information" or "PHI"). There are a number of situations in which we may use or disclose your PHI to certain third parties. There are certain uses and disclosures which require you to sign an Acknowledgement that you received our Notice of Privacy Practices. Any use or disclosure of your PHI required for anything other than treatment, payment, or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the disclosure.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. You can request an updated copy of this notice from our office at any time.

II. Use and Disclosure without Acknowledgement:

We may use basic information such as your name, email, or text/phone to communicate with you. However, you have the right to choose your preferred method of communication, which may include text, email, or phone call.

We may use and disclose your PHI without your authorization for the following reasons:

1. For Treatment. We may use and disclose PHI without specific consent to provide, coordinate, and manage health care and related services. These activities include coordination or management of health care with other third parties; consultation among other health care providers; and patient referrals among health care providers.

2. For Payment. To obtain payment and/reimbursement for treatment, we may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claims. Information may be used per request from insurance company to file claims.

3. For Health Care Operations. We may use and disclose PHI in connection with our standard business operations, including quality assessment and improvement activities. Examples include (i) obtaining accreditation from independent organizations, (ii) outcome evaluation and development of clinical guidelines, (iii) case management and care coordination, (v) contacting of health care providers and patients with information about treatment alternatives and related functions, (vi) evaluations of health care providers (credentialing and peer review activities) and health plans, (vii) underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of health benefits contracts, (viii) obtaining reinsurance, stop-loss, and excess loss insurance; (ix) conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs, (x) business planning and development, and (xi) business management and general administrative activities, including data and information systems management, customer service,

resolution of internal grievances, and sales, mergers, transfers, or consolidations with other providers or health plans or prospective providers or health plans .

4. For Administrative or Public Health Concerns. We may disclose your PHI in certain circumstances regarding public health and oversight activities, law enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

III. Use and Disclosure with Authorization:

Except as outlined in the above, your PHI will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

IV. Additional Uses and Disclosures:

1. Appointment Reminders and Other Services. We may contact you to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits.

2. Marketing. We shall obtain your written authorization prior to using your PHI to send you any marketing materials; however, we may provide you with marketing material in a face-to-face encounter, without obtaining Authorization.

3. Public Health and Safety. We may use or disclose PHI as necessary to prevent or reduce a serious and imminent threat to the health or safety of a person or the public, to people who may be able to reduce the threat, including the threatened person or law enforcement officials; or for other public health activities, to public health authorities (such as the Pennsylvania Department of Health or the U.S. Department of Health and Human Services) engaged in preventing or controlling disease, injury, or disability. We also may disclose PHI to manufacturers of drugs, biologics, devices, and other products regulated by the federal Food and Drug Administration when the information is related to their quality, safety, or effectiveness. PHI also may be disclosed to certain people exposed to communicable diseases and to employers in connection with occupational health and safety or worker's compensation matters.

4. Other Government Functions. We may disclose the PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

5. Workers' Compensation Purposes. We may provide PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs established by law.

6. Family, Friends, or Other Third Parties. With your written consent, which may be revoked at any time, we may provide your PHI to a family member, friend, or other designated third party that you indicate is involved in your care or the payment for your health care .

7. Death. We may disclose PHI to coroners or medical examiners to identify a person who has died, determine the cause of death, or perform other functions authorized by law; and (before or after death) to funeral homes as necessary to carry out their duties. In addition, PHI of a person who has died may be used or disclosed in connection with research that does not involve any live subjects

V. Individual Rights:

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures. You have the right to request that we restrict the use and disclose your PHI for treatment, payment, and operations. We will consider your request, but we are not required to accept it. If we agree to your requested restriction, we shall comply with the restriction, except with respect to emergencies, disclosures to you, or if we are required by law to make full disclosure without restriction .

2. The Right to Request a Receipt. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

3. The Right to Inspect and Request Copies. You have the right to inspect, copy, and request amendment to your PHI. Access to your PHI will not include physical therapy notes contained in them or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information .

All requests for inspection, copying, and/or amending your PHI must be made in writing. We will respond to your request within thirty (30) days or receipt of the request.

4. The Right to Receive Accounting Disclosures. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your PHI, except for disclosures required for treatment, payment, and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law.

We will respond within sixty (60) days of receiving your request. The list we will give you will include disclosures made in the last two (2) years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge.

5. The Right to a Physical Copy. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

VII. Our Duties:

We have the following duties with respect to the maintenance, use, and disclosure of your PHI:

1. We are required by law to maintain the privacy of the PHI in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information;

2. We are required to abide by the terms of this Notice currently in effect; and

3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available, at our office.

VIII. Complaints:

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and sent to _____ (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint .

FINANCIAL POLICY

Insurance:

Mobile Physio is currently contracted with Medicare and accepts most Medicare Advantage Plans as insurance providers for physical therapy services. Your insurance policy with Medicare or a Medicare Advantage Plan represents a formal agreement between them and you. To facilitate accurate billing to the insurance company, it's imperative that you provide us with up-to-date and valid insurance details. You are responsible for notifying us of any changes with your insurance in a timely manner. Any services rendered to you during a lapse in your insurance coverage will be your responsibility to pay. We undertake the task of submitting claims to Medicare/Medicare Advantage on your behalf. It's important to note that services covered under Medicare Advantage plans vary based on the plan. Should your plan deem a particular service as "not covered," you will bear full responsibility for the associated charges. It's crucial to understand that Mobile Physio does not assume responsibility for challenging decisions made by your insurance carrier regarding coverage.

For all other commercial and private insurances that Mobile Physio is not contracted with, we will supply you with the forms needed to submit a reimbursement request to your insurance company. You will be required to pay our bill in full at the time of the visit.

Deductibles/Payments/Co-payments:

Our insurance contracts require us to collect any deductibles, coinsurance and copays, all of which will be collected at the time of or prior to the first visit. All copayments will be due at the time of service. You are responsible for the timely payment of any account balance. For your convenience we accept debit, credit, and HSA/FSA cards, as well as personal checks and cash. When you provide a check as payment, you authorize us to use information from your check to make a one-time electronic fund transfer from your account.

Referral and Continued Treatments

You understand that in the Commonwealth of Pennsylvania, matters related to practicing physical therapy without a physician referral, if we are evaluating and treating you without a referral, after thirty (30) days of treatment we are obligated to obtain a referral from a licensed physician before continuing physical therapy services. You also understand that there may be other instances where we must contact your physician, such as when symptoms are present for which physical therapy is a contraindication, cases where treatment is outside the scope of practice of physical therapy, and cases where treatment is beyond our education, expertise, or experience. You give consent for us to send documentation of your physical therapy evaluation and treatment sessions to your physician(s) when necessary.

CONSENT FOR TREATMENT AND WAIVER OF LIABILITY

Explanation of Treatment:

My physical therapist from Mobile Physio LLC will explain the results of my physical therapy evaluation, the proposed physical therapy interventions within the plan of care, and the reasonable degree of progress that can be expected with my condition. I understand my therapist will explain the associated risks with the physical therapy treatment, as well as the risks of not proceeding with physical therapy and receiving no treatment. I also understand that there is no guarantee of progress with physical therapy services.

Acknowledgement of Risks:

I acknowledge the risks involved in the Services, as defined herein. These include but are not limited to exacerbation of symptoms, pain, stroke, seizure, cardiac symptoms, and death. I acknowledge that I am participating voluntarily, and that all risks have been made clear to me. Additionally, I represent that I do not have any conditions that will increase my likelihood of experiencing injuries while engaging in this activity.

Release:

I release Mobile Physio LLC from all liability relating to injuries that may occur during the performance of mobile physical therapy and/or wellness activities (the "Services") by Mobile Physio LLC or any of its employees or agents. By signing this agreement, I acknowledge and agree to hold Mobile Physio LLC and its affiliates and respective members, officers, directors, employees, and agents harmless from and against all claims, losses, liabilities, damages, expenses, and costs, including attorney's fees and court costs, arising out of the performance the Services.

Safety and Communication:

I will obey safety precautions as listed in writing and as explained to me verbally. I will ask for clarification when needed. I have not withheld any information that would benefit the physical therapist in creating a safer therapy program. I understand that I am encouraged to ask my physical therapist questions and express any concerns I have with the plan of care during the course of my treatment.

Right to Decline or Withdraw:

I reserve the right to decline any part of my proposed physical therapy plan of care, as well as reserve the right to withdraw from Mobile Physio's Services in accordance with Mobile Physio's termination provisions.

GENERAL CONSENT, INSURANCE, AND PRIVACY NOTICE

Consent to Treatment:

I hereby give consent to the physical therapists at Mobile Physio LLC to provide me with physical therapy treatments to myself for my conditions or other matters warranted for physical therapy treatment.

Insurance Responsibility:

I agree it is my responsibility to know and understand my insurance policy regarding referrals, physical therapy pre-certifications, deductibles, co-insurance, and co-payment, as it relates to out-of-network policy or Medicare. Mobile Physio is not obligated to withhold our statements or to wait until settlement has been made before receiving payment for our services.

Assignment of Benefits:

Where applicable, I authorize my insurance company to pay my benefits directly to Mobile Physio LLC and I understand that I will be fully responsible for any outstanding balance on my account. This is a direct assignment of my rights and benefits under this Consent. This payment will not exceed my indebtedness to Mobile Physio LLC and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Privacy Policy:

I have been provided an opportunity to review and have received a copy of Mobile Physio's privacy policies. All efforts to maintain your security and privacy have been made to the best of the ability at Mobile Physio LLC.

Financial Responsibility:

Mobile Physio LLC reserves the right to utilize the services of a collection agency in collecting delinquent accounts. If a collection service is utilized, I agree to pay all such costs incurred in collecting my account balance, including attorney’s fees. If my check is returned for insufficient funds, I agree to pay a returned check fee of $25 for each occurrence.