Informed Consent for Physical Therapy Services

Physical therapy aims to address disease, injury, and disability through assessment, diagnosis, prognosis, and intervention. It utilizes rehabilitative procedures, mobilization, active release techniques/massage, strength training, cardiovascular exercises, and physical agents/modalities to promote faster recovery and restore the ability to function independently.

Before performing any procedures, they will be fully explained to you. Physical therapy treatments carry certain inherent risks, as they may involve exerting effort and performing activities with increasing difficulty, which could lead to heightened pain or discomfort, particularly with a current or past injury. You have the right to ask your physical therapist about the planned treatment based on your personal history, diagnosis, symptoms, and examination results. You also have the right to discuss the potential risks and benefits of the treatment. If you experience any pain or discomfort, you can stop the treatment. Your therapist will take all necessary precautions to ensure your safety and protect you from any possible hazards. You will never be pressured into performing any procedure you do not wish to do. By acknowledging this information, I agree to fully cooperate, participate in all physical therapy procedures, and follow the established plan of care.

I understand that the physical therapist cannot guarantee a cure or improvement in my condition. I acknowledge that my physical therapist will provide me with their professional opinions, along with relevant statistics and studies related to the outcomes of physical therapy for my condition, and will discuss the available treatment options with me before I give my consent.

If utilizing concierge services, I give my consent, by signing below, for treatment ("informed consent") and agree that the treatment may take place at my home, gym, workplace, or any other location we have previously agreed upon.

I have read the consent form and authorize the release of my medical information to relevant third parties. I hereby release Reeverts Rehabilitation and Performance Training LLC from any responsibility or liability related to my participation in physical therapy. I understand that I am participating in these sessions at my own risk and agree not to hold the aforementioned parties responsible for any injury or worsening of pre-existing conditions. If I have any medical conditions, I have consulted with my physician to ensure that physical therapy is suitable for me.

_____ _____

Patient Signature or Guardian Signature Date

TERMS & CONDITIONS

No Show and Cancellation Policy

- **Cancellation Policy:** Patients who do not cancel their appointment at least 24 hours in advance will receive a reminder and a one-time grace period without a fee for the first occurrence. For the second occurrence and any subsequent cancellations, a $40 fee will be charged. In the case of an emergency where prior notice could not be given, Reeverts Rehabilitation and Performance Training LLC may, at its discretion, offer a one-time grace exception. I understand that if I arrive more than 10 minutes late for my scheduled appointment, I can choose to keep the appointment with a shortened duration at the full price, or I can cancel and incur a $25 late cancellation fee.
- **No Show Policy:** Patients who fail to attend an appointment without prior notice, will be charged a $50 no-show fee.

Responsibility for Payment

Reeverts Rehabilitation and Performance Training LLC is not currently in-network with any major insurance providers. Our clinic accepts cash payment at the time of service, and we can provide a superbill for you to submit to your insurance. However, this does not guarantee insurance coverage or reimbursement. In the event of a late cancellation or no-show, I will be invoiced, and payment must be received before scheduling my next session. I acknowledge that, in exchange for the services provided by Reeverts Rehabilitation and Performance Training LLC, I am fully responsible for paying my bill at the time of service via cash, check, credit card, HSA card, or FSA card.

Strength training services, when not a part of a physical therapy plan of care, cannot be paid for with use of an HSA or FSA.

Consent to Communicate

I understand and acknowledge that Reeverts Rehabilitation and Performance Training LLC may communicate with me via email and/or text message regarding scheduling, treatment, billing, and other healthcare operations using the contact information I have provided. I understand that such communications may include protected health information (PHI) and that email and text messaging may not be encrypted, may be subject to interception or unauthorized access, and may not fully comply with HIPAA security requirements. I acknowledge and accept these risks. I understand that this consent is required to receive services and may be revoked in writing; however, revocation may affect Reeverts Rehabilitation and Performance Training LLC's ability to communicate with me regarding my care.

____ I Consent to Required Electronic Communications

FEDERAL HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice explains how your medical information may be used and shared, as well as how you can access it. Please read it carefully.

"We": refers to Reeverts Rehabilitation and Performance Training LLC. "You" or "yours" refers to any individual receiving treatment by Reeverts Rehabilitation and Performance Training LLC employees.

Federal law, specifically the Health Insurance Portability and Accountability Act (HIPAA) and associated privacy regulations, requires Reeverts Rehabilitation and Performance Training LLC to protect your health information. We are prohibited from using or disclosing your information without your consent, unless allowed by law. This law also mandates that we provide you with this notice outlining our legal responsibilities and privacy practices. This notice details how we may use and disclose your health information, as well as your rights and our responsibilities in handling it.

We are required to comply with the terms of this Notice. However, we reserve the right to update the terms of this Notice and apply the new provisions to all the health information we maintain, including information collected before any changes to this Notice. If there is a significant change in how we use or disclose information, your rights, our responsibilities, or other related matters, we will promptly update this Notice. To receive these updates via email, please contact the person listed at the end of this Notice.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Under the privacy regulations, we are permitted to use and disclose your health information for the following purposes:

Uses and Disclosures for Treatment: We will use and disclose your protected health information as needed for your treatment. Healthcare providers, including doctors, nurses, and other professionals involved in your care, will access information in your medical record as well as details you provide about your symptoms, responses to treatment, and other relevant information such as procedures, medications, tests, and medical history.

Uses and Disclosures for Payment: We will use and disclose your protected health information as needed for payment purposes. In the course of our regular business operations, we may use your information to generate a bill for you or the individual responsible for your payment.

Uses and Disclosures for Health Care Operations: We will use and disclose your protected health information as necessary and as permitted by law for our healthcare operations. This may

include activities such as clinical improvement, professional peer review, business management, accreditation, and licensing. For example, we may use and disclose your information to enhance clinical treatment and patient care.

Individuals Involved In Your Care: We may, at times, disclose your protected health information to designated family members, friends, or others involved in your care or the payment for your care, in order to assist with their involvement in your treatment or payment process. If you are unavailable, incapacitated, or in an emergency medical situation, and we believe a limited disclosure is in your best interest, we may share a limited amount of your information with these individuals without your consent. Additionally, we may disclose limited protected health information to a public or private entity authorized to assist in disaster relief efforts, to help locate a family member or other individuals involved in your care.

Business Associates: Some aspects of our services are carried out through contracts with external individuals or organizations, such as auditing, accreditation, outcomes data collection, and legal services. In certain situations, we may need to share your protected health information with these external partners who assist us with our healthcare operations. We ensure that all of these partners take appropriate measures to protect the privacy of your information.

Appointments and Services: We may contact you with appointment updates or information about your treatment and other health-related benefits and services that may interest you. You have the right to request, and we will accommodate reasonable requests, to receive communications regarding your protected health information by alternative methods or at alternative locations. For example, if you prefer not to receive appointment reminders via voicemail or to a particular address, we will honor such requests. You must provide an appropriate alternative contact method or address for these communications. Additionally, you have the right to request that we do not send you any future marketing materials, and we will make every effort to comply with your request. To make these requests, please submit them in writing, including your name and address, to the person listed at the end of this Notice.

Students: Students and interns in health-related programs may observe or assist in your treatment as part of their training. You have the right to refuse their involvement in your care—inform your provider if you prefer not to participate.

Research: In certain situations, we may use and disclose your protected health information for research purposes. When your specific authorization is not obtained, your privacy will be safeguarded by strict confidentiality measures imposed by an Institutional Review Board overseeing the research, or by assurances from the researchers that restrict how your information is used and disclosed.

Marketing: We may use or share your health information to send marketing communications to you if the communication is made in person or relates to products or services of minimal value.

For marketing communications that don't meet an exception to the authorization requirement (like in-person communications), we will not send you marketing materials for which we receive compensation without your consent.

Fundraising: We may use your information to reach out to you for fundraising purposes. Additionally, we may share your contact information with a related foundation so that they can contact you for similar purposes. If you prefer not to receive fundraising communications from us or the foundation, you can submit your request in writing to the contact listed below.

PERMITTED DISCLOSURES

While we may not use or disclose your information in all the ways listed here, federal law allows us to do so without your consent in certain situations.

- When disclosure is required by law
- To a public health authority authorized by law to collect or receive your information for the purpose of preventing or controlling disease, injury, or disability, or when investigating reports of child abuse or other public health activities
- To a health oversight agency for relevant activities
- If there is reasonable belief of abuse or neglect
- For judicial and administrative proceedings
- To law enforcement officials for law enforcement purposes
- To the FDA and other regulatory agencies regarding adverse events, product issues, or post-marketing monitoring to support recalls, repairs, or replacements.
- To a medical examiner to identify a deceased person, determine the cause of death, or carry out other duties authorized by law
- To organ donation organizations to support donations
- For specific research purposes permitted and regulated by federal law
- To prevent a serious threat to health or safety
- To government officials concerning military personnel or specific domestic and foreign government officials for duties authorized by federal law
- To comply with workers' compensation and similar programs

PATIENT RIGHTS

While your medical record is property of Reeverts Rehabilitation and Performance Training LLC, you have the following rights regarding your medical record and health information:

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your information. However, we are not obligated to agree to these requests. If we do agree, we will not use or disclose your information except when emergency treatment is required. We may also end any

agreement to restrict as permitted by federal law. For more information, you can contact the person listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED INFORMATION: You have the right to view and obtain a copy of your information, as well as certain information related to civil, criminal, or administrative proceedings, and any information that is legally restricted from disclosure. Any request should be made in writing to the contact listed at the end of this Notice. For additional information, please reach out to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO VERBALLY OBJECT: You have the right to verbally object to certain disclosures of your health information that are typically made for treatment, payment, healthcare operations, or other purposes without needing an Authorization. For instance, we must offer you the opportunity to object to sharing your health information with a person or family member who is accompanying you for treatment.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO SEEK AN AMENDMENT OF YOUR HEALTH INFORMATION: You have the right to request a change to your health information. If we do not agree with the requested change, you may add a statement to your record. Additionally, we will provide a written explanation outlining the reasons for the denial and the process for submitting complaints and appeals.

FEDERAL LAW PROVES YOU THE RIGHT TO AN ACCOUNTING OF DISCLOSURE OF YOUR HEALTH INFORMATION: You have the right to request a record of disclosures of your health information made by us within the six (6) years preceding your request. This record will not include disclosures related to treatment, payment, or healthcare operations; disclosures made directly to you; those made with a valid authorization; disclosures permitted under Privacy Regulations; or those shared with individuals involved in your care. The accounting will detail the date of each disclosure, the name and address of the recipient, a brief description of the disclosed information, and the purpose of the disclosure.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION: If you request that your information be sent to you by a specific method or to a particular address, we will accommodate your request if it is reasonable. You must clearly indicate that disclosing all or part of your information through other means could put you at risk. Any such request should be submitted in writing to the contact listed at the end of this Notice. For further information, please contact the person listed at the end of this Notice.

WHEN AUTHORIZATIONS ARE REQUIRED: Your authorization is required for most uses and disclosures of psychotherapy notes (when applicable), as well as for using or disclosing your health information for marketing purposes or any disclosures that involve the sale of protected

health information. Additionally, any other uses and disclosures of your health information not covered in this Notice of Privacy Practices will only occur with your valid authorization.

FEDERAL LAW PROVIDES YOU THE RIGHT TO REVOKE YOUR AUTHORIZATION: You have the right to revoke a previously authorized use or disclosure of your health information. However, the revocation will not affect any uses or disclosures that occurred before we received your request.

FEDERAL LAW PROVIDES YOU THE RIGHT TO BE NOTIFIED FOLLOWING A BREACH OF YOUR INFORMATION: If a breach of your unsecured protected health information occurs through us or our business associates, you have the right to be notified.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, even if you have agreed to receive it via email. All requests must be made in writing and sent to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you have the right to file a complaint with us by sending a written request to the contact listed at the end of this Notice. Federal law prohibits any retaliation against you for filing such a complaint. The contact at the end of this Notice is also available to answer any questions or provide additional information regarding this Notice.

THE CONTACT TO WHOM YOU SHOULD ADDRESS YOUR COMPLAINT IS:

Reeverts Rehabilitation and Performance Training LLC

Dr. Jake Reeverts, PT, DPT, LAT, ATC, CSCS – License Number: 05014258A

Telephone Number: 815-876-7543

The effective date of this notice is 3/17/25.

HIPPA COMPLIANCE:

I acknowledge that Reeverts Rehabilitation and Performance Training LLC may use or disclose my personal health information (PHI) for purposes such as treatment, payment, quality assessment of services provided, and administrative operations related to treatment or payment. I understand that I have the right to request restrictions on how my PHI is used and disclosed for treatment, payment, and administrative operations by notifying the practice. I also understand that while Reeverts Rehabilitation and Performance Training LLC will review these requests on a case-by-case basis, it is not obligated to approve any restriction requests.

I consent to the use and disclosure of my PHI for the purposes outlined in Reeverts Rehabilitation and Performance Training LLC's Notice of Information Practices, of which I have read. I understand that I can revoke this consent at any time by notifying the practice in writing.

_____ _____

Patient Signature or Guardian Signature Date