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NEW PATIENT INTAKE, NOTICES, CONSENTS AND FINANCIAL AGREEMENT

Please complete this entire packet and read it in full before signing. It combines your new-patient intake information (Part I) with the notices, consents, and financial agreement required for your care at FIT PARSONS PT (Part II), organized into Sections A through G. Each notice or consent section in Part II is complete and independent — nothing has been shortened or removed from the individual disclosures — and each requires your separate initials in addition to your signature at the end of the packet. If you have questions about any section, please ask our staff before signing; do not sign any section you do not understand or agree with.

Not included in this packet: the CMIA Authorization for Release of Medical Information to a third party (e.g., an attorney, employer, or another provider) is intentionally kept as a separate, stand-alone form. California and federal law prohibit conditioning treatment on signing a third-party release authorization, and a valid authorization must identify the specific recipient, information, purpose, and expiration at the time it is needed — details that do not exist yet at intake. You will be asked to complete that separate form only if and when you request that your records be sent to a specific third party.

Patient Name (Last, First): _____

Today's Date: _____

This name and date apply throughout the packet. Each section below still requires its own initials or signature.

PART I — PATIENT INFORMATION AND HEALTH HISTORY

1. Contact & Demographic Information

First Name: _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____

Cell Phone: _____ **Work Phone:** _____

Email: _____

May we: **Text You?** Yes | No **Leave a Message?** Yes | No **Email You?** Yes | No **Consent to Tele-Health?** Yes | No

Occupation: _____ **Employer:** _____

Employment: Full Time | Part-Time | Not Working | Retired | Self-Employed | Student

Referring Doctor: _____ **Phone:** _____

Primary Doctor: _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone: _____

Parent/Guardian Name(s) & Relationship(s): _____

Parent/Guardian Marital Status: Married | Divorced | Single | Widowed | Domestic Union

Physical Custody: _____ **Legal Custody:** _____

How did you hear of FIT PARSONS: _____

What brings you to PT: _____

2. Condition & Medical History**Date of Injury / Onset Date:** _____ **Surgery Date:** _____**Surgery Type (if applicable):** _____**Is this Auto Related?** Yes / No**Work Related?** Yes / No**Accident Related?** Yes / No**Is an attorney involved?** Yes / No**Current/Former smoker?** Yes / No**Pregnant?** Yes / No**Pain Level (0 = no pain, 10 = worst pain imaginable):** _____**Would you say your condition is:** Improving | Staying the same | Getting Worse**What helps your condition feel better:** _____**What makes your condition feel worse:** _____**Please list any ALLERGIES you have:** _____**Diagnostic exams you have had for your current condition (x-rays, MRI, CT scan, etc.):** _____**Please list any surgeries (with dates) & assistive devices you use:** _____**Medications (and doses) you are currently taking — attach a separate sheet if needed:** _____**Goals for Physical Therapy:** _____**3. Health History Checklist****Do you or have you had any of the following? Circle or check all that apply and explain below.**☐ High Blood Pressure☐ Neurological Disorders☐ High Cholesterol☐ Unexplained Falling☐ Type I or Type II Diabetes☐ Pain Worse at Night☐ Heart Attack or Heart Conditions☐ Unexplained Weight Loss / Gain☐ Pacemaker☐ Headaches or Blurred Vision☐ Cancers of any kind☐ Dizziness or Ringing in Ears☐ COPD, Asthma, Emphysema☐ Difficulty Swallowing☐ Stroke or Blood Clots☐ Active Infection, Fevers, Chills☐ Seizures/Epilepsy☐ Loss of Bowel / Bladder Control☐ HIV / AIDS☐ Osteoporosis / Osteopenia☐ Hepatitis B☐ Metal Implants & Location**Explain the above & any other health info FIT PARSONS PT should know:** _____**4. Pediatric Patients Only***Complete this section only if the patient is a minor (under 18 years of age).***Weeks Gestation at Birth:** _____ **Vaginal / C-Section:** _____ **Complications Y/N:** _____**Breastfeeding — how long:** _____ **Siblings & Age(s):** _____*Age when your child started (leave blank if not yet, or not applicable):***Rolling:** _____ **Sitting:** _____ **Crawling:** _____ **Pull to Stand:** _____**Cruising:** _____ **Standing Indep.:** _____ **Squatting:** _____ **Walking:** _____**Other Caregiver:** _____ **School Attending:** _____ **Grade:** _____**Additional health info about your child:** _____

PART II — NOTICES, CONSENTS AND FINANCIAL AGREEMENT

The remaining sections (A through G) contain the notices and consents required by California and federal law for your care at FIT PARSONS PT, along with the practice's financial and cancellation policies. Please read each section in full, initial where indicated, and sign the final acknowledgment in Section G.

SECTION A — Notice to Consumers (PTBC)

Required by Title 16, California Code of Regulations, Section 1398.15

Did You Know?

The Physical Therapy Board of California licenses and regulates your Physical Therapist and Physical Therapist Assistant. A Physical Therapy Aide, while regulated by the Board, is not licensed.

Visit the Board's website at www.ptbc.ca.gov for information on:

- Verifying a license
- What to expect when you receive care
- Your rights as a patient
- How to file a complaint

Board Contact Information

Physical Therapy Board of California — 2005 Evergreen Street, Suite 2600, Sacramento, CA 95815 — 1-800-832-2251 — www.ptbc.ca.gov

Title 16, California Code of Regulations, section 1398.15 requires all licensed physical therapists to provide this notice, either by posting it prominently where patients can see it, or by giving each patient a copy and retaining a signed acknowledgement in the patient's record.

By initialing below, I acknowledge that I have received a copy of this Notice to Consumers.

Section A — Notice to Consumers (PTBC)

Initials: _____

Date: _____

SECTION B — Notice of Privacy Practices

Governed by HIPAA and the California Confidentiality of Medical Information Act (CMIA) — Effective Date: 1/1/2020

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

FIT PARSONS PT ("Practice," "we," "us") is required by the Health Insurance Portability and Accountability Act ("HIPAA") and the California Confidentiality of Medical Information Act ("CMIA") to protect the privacy of your health information, provide you with this Notice of our legal duties and privacy practices, and abide by its terms while it is in effect.

1. How We May Use and Disclose Your Health Information

We may use and disclose your health information, without your written authorization, for the following purposes:

- **Treatment:** To provide, coordinate, and manage your physical therapy care, including consultation with other treating providers.
- **Payment:** To collect payment for services by the responsible payer.
- **Healthcare Operations:** For quality assessment, staff training, licensing, and related administrative purposes.
- **As Required by Law:** Including in response to a valid subpoena or court order, and other disclosures specifically required by state or federal law.
- **To Avert a Serious Threat to Health or Safety:** When necessary to prevent or lessen a serious and imminent threat to your health or safety or that of another identifiable person.
- **Mandated Reporting:** California law requires physical therapists to report suspected abuse or neglect of a child, elder, or dependent adult to the appropriate authorities. This reporting is required by law and does not require your authorization.

Uses and disclosures for any other purpose require your specific written authorization. We will ask you to complete a separate CMIA-compliant Authorization to Release Medical Information. You may revoke a written authorization at any time, except to the extent we have already acted on it.

Marketing Communications

We may contact you, without additional authorization, to provide appointment reminders and information directly related to your treatment. Any other marketing communication — including information about services, products, or health-related offers not directly tied to your ongoing treatment — requires your separate, specific written authorization. We will not send you this type of communication unless you have affirmatively opted in.

2. Electronic Transmission and Storage of Your Information

We use Google Workspace to create, receive, maintain, and transmit certain health information as part of treatment, payment, and healthcare operations (for example, scheduling, treatment notes, and billing records). Google LLC acts as our business associate under a signed Business Associate Agreement and is contractually obligated to safeguard your information consistent with HIPAA. We have configured our systems with access controls, multi-factor authentication, and activity monitoring intended to protect your information. A summary of these safeguards is available upon request. Separately, if you consent to receive routine communications by email or text, that consent and its associated risks are described in our Patient Consent for Electronic Communications.

3. Your Rights Regarding Your Health Information

- **Right to Inspect and Copy** your medical record, generally within 15 days of a written request.
- **Right to Amend** your health information if you believe it is incorrect or incomplete.
- **Right to an Accounting of Disclosures** we have made of your health information, other than for treatment, payment, and healthcare operations.
- **Right to Request Restrictions** on certain uses or disclosures, which we are not always required to accept.
- **Right to Request Confidential Communications** by alternative means or at an alternative location.
- **Right to a Paper Copy** of this Notice at any time, even if you previously agreed to receive it electronically.
- **Right to Choose an Authorized Representative** to exercise these rights on your behalf, with appropriate documentation (such as a power of attorney).
- **Right to Be Notified of a Breach** of your unsecured health information, as described in Section 5 below.

4. Our Responsibilities

- Maintain the privacy and security of your health information as required by HIPAA and the CMIA.
- Provide you with this Notice of our legal duties and privacy practices.
- Abide by the terms of this Notice currently in effect.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests to communicate by alternative means or at alternative locations.

We reserve the right to change our privacy practices and to make revised terms effective for all health information we maintain. If we make a material change, we will post the revised Notice in our office and on our website, and will provide a copy upon request.

5. Breach Notification

If a breach of your unsecured health information occurs, we will notify you as required under HIPAA and, under California Health and Safety Code section 1280.15, will report unauthorized access to, or use or disclosure of, your medical information to the California Department of Public Health and to you within the timeframes required by that statute.

6. Your Rights Under the CMIA

In addition to your rights under HIPAA, the California Confidentiality of Medical Information Act gives you an independent right to bring a civil action for unauthorized release of your medical information, including statutory damages, under California Civil Code section 56.36. Nothing in this Notice, or in any consent or agreement you sign with us, waives or limits that right.

7. Record Retention

We retain medical records consistent with California physical therapy licensing requirements and the CMIA — generally for a minimum of seven (7) years from the date of your last treatment, or, for a minor patient, until the patient's 19th birthday, whichever period is longer.

8. Complaints

If you have questions about this Notice or believe your privacy rights have been violated, contact our Privacy Officer:

Stacey Parsons, Privacy Officer — FIT PARSONS PT, 205 Avenue I, Suite 25, Redondo Beach, CA 90277 — Phone: 424-290-0096 — Fax: 424-408-3320 — info@fitparsons.com

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at www.hhs.gov/ocr/complaints, or with the California Department of Public Health. You will not be retaliated against for filing a complaint.

For a summary of your privacy rights under HIPAA, see: <https://www.hhs.gov/sites/default/files/privacysummary.pdf>

Acknowledgment of Receipt: My initials below acknowledge that I have received a copy of this Notice of Privacy Practices. Signing this acknowledgment does not waive any right I have under HIPAA, the CMIA, or other applicable law.

Section B — Notice of Privacy Practices (HIPAA/CMIA)	Initials: _____	Date: _____
SECTION C — Consent to Physical Therapy Evaluation and Treatment		

Intake Consent — including Telehealth and Minor Patients

TO THE PATIENT: You have a right to be informed about your condition and the physical therapy evaluation and treatment recommended, so that you can make an informed decision about whether to proceed after understanding the risks, benefits, and alternatives involved. This is the consent covering your evaluation, treatment, telehealth (if used), and related preferences at FIT PARSONS PT — please read it in full.

This consent authorizes FIT PARSONS PT to perform the physical therapy evaluation reasonably necessary to identify appropriate treatment for your condition(s), and to provide physical therapy treatment consistent with that evaluation, within the scope of practice of a physical therapist licensed in California. This consent does not authorize, and FIT PARSONS PT does not provide, medical diagnosis, prescription of medication, dry needling, or any procedure outside the physical therapy scope of practice.

1. Nature, Risks, Benefits, and Alternatives

Physical therapy treatment may include manual (hands-on) therapy, therapeutic exercise, balance and gait training, postural and movement training, patient education, and therapeutic modalities (such as heat, cold, or electrical stimulation). As with any treatment,

risks may include temporary soreness, muscle strain, skin irritation from modalities, dizziness, or, rarely, a fall during balance or mobility training or aggravation of your condition. Anticipated benefits include improved pain, strength, mobility, and function, though results cannot be guaranteed and vary by individual. Alternatives — including no treatment, or evaluation and treatment by another type of provider — have been discussed with you as applicable to your condition.

2. Physical Contact and Manual Therapy

Physical therapy evaluation and treatment routinely involves physical contact, including palpation, manual therapy techniques, and guided movement, for the purpose of assessment and treatment. By initialing below, you consent to this physical contact. You have the right to ask your physical therapist to explain any technique before it is performed, to decline any part of your treatment, and to request that a chaperone be present during any examination or treatment (see Section D).

3. Continuous Nature of Consent; Locations

(1) This consent is continuous for the course of physical therapy described above, including after a specific physical therapy diagnosis and treatment plan has been established, and remains effective until you revoke it in writing. Revocation will not affect care already provided.

(2) You consent to treatment at this office or any FIT PARSONS PT location under common ownership within California. This consent does not extend to any location or provider outside this practice.

4. Telehealth Consent

(3) You consent to receiving some services by telehealth (live audio and/or video), when your physical therapist determines it is clinically appropriate, and you understand that:

- Telehealth is provided on a platform for which FIT PARSONS PT has administrative, technical, and physical safeguards in place; however, no electronic platform is completely free of risk, and you should enable available privacy/encryption settings on your device.
- You may decline telehealth and request in-person services instead, at any time, without it affecting your right to future care.
- If a telehealth session is interrupted by a technology failure, your provider will attempt to reconnect or will reschedule the remainder of the visit.
- Telehealth is not appropriate for emergencies. If you are experiencing a medical emergency, call 911 or go to the nearest emergency room.
- You must be physically located in California during any telehealth visit with this practice.

5. Your Rights

I understand that if I have any concerns regarding the purpose, risks, and benefits of any evaluation or treatment recommended or provided, I can discuss it with my physical therapist and, if applicable, my treating physician. I understand that I may decline or discontinue any evaluation or treatment technique at any time, without it affecting my right to future care.

6. Photography and Video

From time to time, we may wish to take photographs or video of your movement or treatment to document your progress or for patient education. Clinical documentation images/video are part of your medical record and are never shared outside your care team without your separate authorization.

7. Minor Patients — Additional Consent Required

Complete this section only if the patient is under 18 years of age.

Name of Minor Patient: _____ **Date of Birth:** _____

As the parent or legal guardian of the minor patient named above, I consent to the minor's physical therapy evaluation and treatment as described in this document. I represent that I have legal authority to consent to health care on the minor's behalf (for example, as a custodial parent, legal guardian, or holder of a healthcare power of attorney or joint legal custody with authority to consent to routine care), and I will notify FIT PARSONS PT promptly if that authority changes.

I understand that California-licensed physical therapists, like other health care providers, are mandated reporters and are required by law to report suspected abuse or neglect of a child to the appropriate authorities, as described in Section B (Notice of Privacy Practices).

The parent/guardian signature for a minor patient is provided in the Final Acknowledgment and Signature section (Section G) at the end of this packet.

8. Acknowledgment

I voluntarily consent to physical therapy evaluation and treatment with FIT PARSONS PT as clinically appropriate for the condition(s) that have brought me (or the minor patient named above) to seek care at this practice. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. Nothing in this consent waives any right I have under the Confidentiality of Medical Information Act (California Civil Code section 56.36) or other applicable law.

If signing as a Personal Representative on behalf of an adult patient, I represent that I have legal authority to consent to physical therapy care on the patient's behalf (for example, as an agent under a healthcare power of attorney or conservator).

Section C — Consent to Evaluation & Treatment

Initials: _____

Date: _____

SECTION D — Patient Comfort and Chaperone Policy

FIT PARSONS PT is committed to providing care in a manner that respects your comfort, privacy, and dignity. Physical therapy evaluation and treatment may involve manual therapy, palpation, observation of movement, and, depending on the area being treated, limited draping or exposure of the treatment area.

1. Your Right to Request a Chaperone

You may request that a trained staff member (a “chaperone”) be present to observe or assist during any examination or treatment, for any reason, including treatment involving the hip, pelvis, groin, chest wall, or other sensitive areas. You may make this request at any time — before, during, or after scheduling — and it will be honored for that visit and any future visit unless you indicate otherwise.

2. Our Practices

- We will inform you in advance if treatment is expected to involve a sensitive area of the body.
- We will document in your record when a chaperone is present at your request or at your physical therapist's determination.

3. Declining a Sensitive Examination or Treatment

You always have the right to decline any examination or treatment technique, and to stop treatment at any time. If your physical therapist determines that a chaperone is necessary for a particular examination or treatment to proceed, and you decline a chaperone, we reserve the right to decline to perform that specific examination or treatment.

4. Regulatory Context

California law (the Medical Safety Chaperone Act, AB 849, effective January 1, 2027) requires certain general acute care hospitals and licensed clinics performing specified sensitive ultrasound examinations to notify patients of the right to a chaperone and make one available on request. This statute is targeted at ultrasound imaging performed by hospitals and licensed clinics and does not, by its terms, apply to a private outpatient physical therapy practice; we have adopted this policy voluntarily as a best practice to protect patient comfort and reduce misunderstandings during hands-on care.

By initialing below, I acknowledge that I have been informed of my right to request a chaperone during any examination or treatment at FIT PARSONS PT.

Section D — Patient Comfort and Chaperone Policy

Initials: _____

Date: _____

SECTION E — Financial Policy, Cancellation Policy, and Assignment of Benefits

1. Financial Responsibility

You are financially responsible for all services rendered at the time of service, regardless of insurance coverage. Upon your request, we may provide you with a superbill to submit to your insurance; however, coverage is not guaranteed, and you remain responsible for any deductible, copayment, coinsurance, or denied charges.

2. Self-Pay and Superbills

FIT PARSONS PT services are considered out-of-network because you are paying out-of-pocket. Payment is due at the time of each service, regardless of your insurance coverage. Upon request, we will provide a superbill containing the information needed for you to seek reimbursement directly from your insurance carrier; providing a superbill does not guarantee reimbursement. Methods of payment accepted are cash, check, Venmo and Zelle.

3. Assignment of Benefits

Because you are treated on a self-pay, out-of-network basis, FIT PARSONS PT does not bill your insurance carrier directly, and no assignment of benefits to the Practice is requested or required for routine care.

4. Cancellation and No-Show Policy

We ask that you provide at least 24 hours' notice if you need to cancel or reschedule an appointment. Appointments cancelled with less than 24 hours' notice, or missed without notice, are subject to a fee of \$125 per occurrence, which is not billable to insurance and is your direct financial responsibility. We understand emergencies happen and will consider exceptions on a case-by-case basis. After one late cancellation, a deposit of \$125 is required to book your next appointment and this cost will be applied to your last visit or any late cancellation or no show, whichever comes first.

5. Overdue Accounts

Accounts more than 7 days past due may be referred to a collection agency. Referral to collections will not include disclosure of the reason for treatment or any clinical details beyond what is necessary to collect the amount owed, consistent with our obligations under HIPAA and the CMIA.

By initialing below, I acknowledge that I have read and understand this Financial Policy, Cancellation Policy, and Assignment of Benefits section, and I agree to its terms.

Section E — Financial Policy & Cancellation Policy

Initials: _____

Date: _____

SECTION F — Direct Access to Physical Therapy — Patient Disclosure and Consent

Required under California Business and Professions Code § 2620.1

Please check the box that applies to you:

☐ I am beginning care at FIT PARSONS PT on the referral of a physician, surgeon, or podiatrist for the condition(s) described in Part I. (If this box applies, the statutory Direct Access notice below does not apply to this condition, but you are welcome to read it. Proceed to Section G.)

☐ I am beginning care at FIT PARSONS PT without a referral from a physician, surgeon, or podiatrist for the condition(s) described in Part I (“Direct Access”). Please read this Section in full and sign the statutory notice below.

1. Your Right to Direct Access

California law allows you to begin receiving physical therapy treatment directly from a licensed physical therapist, without first obtaining a referral or prescription from a physician, surgeon, podiatrist, or other health care provider. This is called “Direct Access.”

This Section explains the conditions that apply to Direct Access care under California Business and Professions Code § 2620.1 and documents your consent to begin treatment on that basis.

2. The 45-Day / 12-Visit Limit

If you do not have a medical diagnosis for your condition from a physician, surgeon, or podiatrist, California law limits Direct Access physical therapy treatment to whichever occurs first:

- 45 calendar days from your first date of treatment, or
- 12 treatment visits.

After this limit is reached, your physical therapist may not continue providing treatment for that condition unless a physician and surgeon, osteopathic physician, or podiatrist first examines you (in person or via telehealth) and signs and dates your physical therapist's plan of care to approve continued treatment.

If you already have a medical diagnosis for your condition from a qualified physician or podiatrist, this 45-day/12-visit limit does not apply to treatment of that diagnosed condition.

3. What Happens at the Limit

Before the 45-day or 12-visit limit is reached, your physical therapist will discuss your progress with you. If continued treatment is appropriate and you do not yet have a qualifying diagnosis or physician approval on file, you will need to obtain an examination and a signed, dated approval of the plan of care from a physician, surgeon, or podiatrist before treatment can continue at this practice. We are happy to provide your plan of care documentation to support that visit.

If you improve and no longer require treatment within the 45-day/12-visit period, no referral is needed.

4. Your Physical Therapist Will

- Evaluate your condition and determine whether it falls within the scope of physical therapist practice.
- Refer you to an appropriate health care provider if your condition is outside that scope, or if red-flag symptoms suggesting a condition requiring medical diagnosis are identified.
- Disclose any financial interest they have in treating you, and comply with Business and Professions Code section 2633.
- With your written authorization, notify your physician and surgeon (if any) that treatment has begun.
- Track your visit count and treatment start date so you are notified before the 45-day/12-visit limit is reached.

5. Cash-Pay / Self-Pay Patients

If you are paying for services directly (self-pay), this Direct Access limit still applies in full — it is a scope-of-practice requirement under state law, not an insurance requirement. Payment method does not change or extend the 45-day/12-visit limit. FIT PARSONS PT's financial policy governing billing, payment, and refund terms is set out in Section E.

6. Statutory Notice (California Business and Professions Code § 2620.1(e))

California law requires that the following notice be provided to you both orally and in writing, in at least 14-point type, and signed by you before a physical therapist provides Direct Access treatment services. Please read the boxed notice below and sign and date it separately from your initials elsewhere in this packet.

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 Podiatric Medical Board of California and acting within their 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 or telehealth patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Patient's Signature: _____ **Date:** _____

Staff use: This notice was also provided to the patient orally, as required by Bus. & Prof. Code § 2620.1(e).

☐ Confirmed — Staff initials: _____

7. Patient Acknowledgment and Consent

By initialing below, I acknowledge that:

- I have read, or had explained to me, the Direct Access disclosure above.
- I understand that, absent a qualifying medical diagnosis, treatment under Direct Access is limited to 45 calendar days or 12 visits, whichever occurs first.
- I understand that continued treatment beyond that point requires an examination and signed approval from a physician, surgeon, or podiatrist.
- I consent to begin physical therapy evaluation and treatment at FIT PARSONS PT on this basis.

Section F — Direct Access Disclosure and Consent

Initials: _____

Date: _____

SECTION G — Final Acknowledgment and Signature

Applies to Part I and to Sections A through F above

By signing below, in addition to the information provided in Part I and the initials/signature provided at the end of each section above, I confirm that:

- I have provided complete and accurate patient information and health history in Part I of this packet.
- I have received and had the opportunity to read (or have had read and explained to me) the Notice to Consumers, the Notice of Privacy Practices, the Consent to Physical Therapy Evaluation and Treatment, the Patient Comfort and Chaperone Policy, the Financial Policy, Cancellation Policy, and Assignment of Benefits, and the Direct Access Disclosure (if applicable) set out in Sections A through F of this packet.
- I will or have had the opportunity to ask questions about each section, and any questions I have had have been answered to my satisfaction.
- I voluntarily consent to the physical therapy evaluation and treatment described in Section C, and I agree to the financial, cancellation, Direct Access, and privacy terms described in Sections A, B, D, E, and F.
- Nothing in this packet waives any right I have under HIPAA, the CMIA (California Civil Code section 56.36), or other applicable law.

Signature of Patient or Personal Representative

Date

Printed Name of Patient

Printed Name of Personal Representative (if applicable)

Relationship to Patient (if signing as Personal Representative): _____

For Minor Patients

Parent/Guardian Signature

Date

Printed Name of Parent/Guardian: _____ Relationship to Minor: _____

Office Use Only: A copy of this fully executed packet has been provided to the patient and the original retained in the patient's medical record.