MOVE Mobile Therapy LLC
Ponte Vedra, FL 32081
Ph: (904) 395-5335
Fax: (904) 342-6257

Consent to Treat

I, _____, understand that I will be participating in private, one-on-one physical therapy, massage therapy, personal training, and/or wellness visits incorporating hands-on treatment, manual passive stretching, spinal mobilization, therapeutic exercises, and traditional conservative treatment techniques so that I can improve my strength, endurance, flexibility, balance, core strength, mobility, and overall health and wellness.

I understand that my therapist is licensed in the state of Florida and is highly trained in the areas above.

By signing below, I am giving my consent to treatment ("informed consent"). And, I also consent for treatment to occur in my home, gym, workplace, hotel room, or other location previously agreed upon.

I have been instructed by my therapist to alert my therapist of any special needs, injuries, preferences, or considerations prior to starting the first visit evaluation and treatment, as these could affect my safety and security during the treatment process.

I understand that by signing below, I release this therapist and MOVE Mobile Therapy LLC of all liabilities for my health and safety during my participation in this treatment process.

I only provide this release with the understanding that my therapist is fully trained and upholds an active professional license in the State of Florida.

Signature: _____

Date: _____

MOVE Mobile Therapy LLC
Ponte Vedra, FL 32081
Ph: (904) 395-5335
Fax: (904) 342-6257

Intake Questionnaire

Date: _____ Name: _____

Address: _____

Date of Birth: _____ Phone: _____

Email: _____

Height_____Weight_____ Occupation: _____

Physician's name and phone number:_____

Is Medicare your primary insurance? Yes No Medicare number _____

Do you have a secondary insurance? Yes No Secondary insurance_____

Secondary insurance member ID number _____

Please rate your health: Excellent Good Fair Poor
Do you exercise regularly? Yes No
If yes, how often and what type of activities?

_____

_____

Medications:
Do you have any medication allergies? Yes No
If yes, please list: _____
Do you take any prescription medications? Yes No
If yes, please list:

_____

_____

_____

_____

Past Medical History: Please circle if you have ever had any of the following:
High blood pressure Arthritis Blood disorders Broken bones Cancer Depression Diabetes
Vascular problems Infectious diseases Kidney problems Low blood sugar Osteoporosis
Lung problems Multiple sclerosis Developmental problems Stroke Thyroid problems
Parkinson's disease Seizures/epilepsy Heart problems Dizziness/vertigo Joint replacement
Other _____
Surgeries _____

MOVE Mobile Therapy LLC
Ponte Vedra, FL 32081
Ph: (904) 395-5335
Fax: (904) 342-6257

Intake Questionnaire

History of Current Problem(s):

When did the problem begin? ____/____/____

What is the issue and how did it occur?

_____

_____

_____

Have you ever had the problem(s) before? Yes No

What did you do for the problem(s)?

_____

_____

_____

What makes the problem better?

_____

What makes the problem worse?

_____

What activities are you not able to do now that you could do before the problem(s)? (Please be as specific as you can; for instance “Unable to reach over my head,” “Unable to bend over”)

_____

_____

_____

What are your goals?

_____

_____

How did you hear about us?

_____

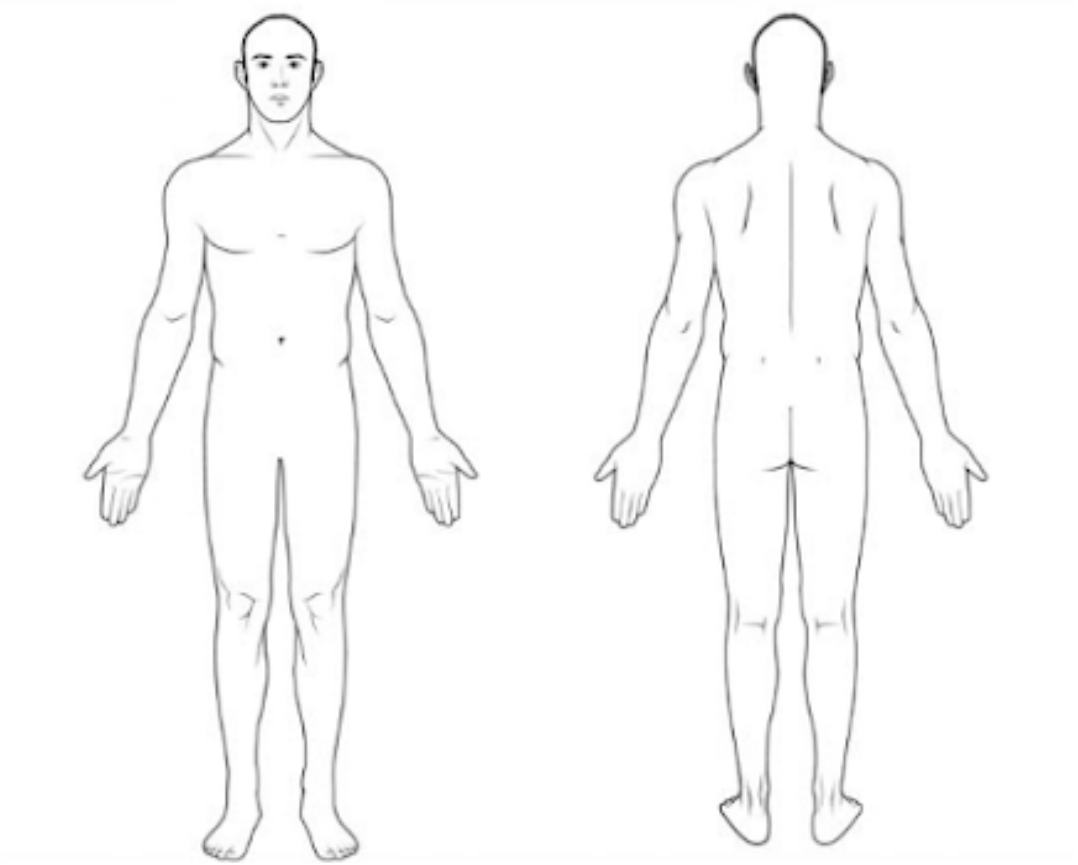
MOVE Mobile Therapy LLC
Ponte Vedra, FL 32081
Ph: (904) 395-5335
Fax: (904) 342-6257

Intake Questionnaire

Rate the level of your pain on the following scale:
Currently: 0 1 2 3 4 5 6 7 8 9 10
At best: 0 1 2 3 4 5 6 7 8 9 10
At worst: 0 1 2 3 4 5 6 7 8 9 10
Pain description (circle all that apply):

Sharp Stabbing Shooting Dull Burning Aching Throbbing Tingling Numbness

Please indicate where you have pain:



MOVE Mobile Therapy LLC
Ponte Vedra, FL 32081
Ph: (904) 395-5335
Fax: (904) 342-6257

HIPAA Notice of Privacy Practices for Protected Health Information

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.

“Federal law” - means the Health Insurance Portability and Accountability Act and related privacy rules, which requires MOVE mobile therapy LLC to keep your health information private. MOVE Mobile Therapy LLC is not allowed to use or disclose it unless we receive your permission or unless permitted by law. Federal law requires MOVE Mobile Therapy LLC to give you this Notice of our legal duties and privacy practices. This Notice is to inform you of uses and disclosures of your health information that MOVE Mobile Therapy LLC may make. It also informs you of your rights and our duties with regard to this health information.

MOVE Mobile Therapy LLC must follow the terms of this Notice. MOVE Mobile Therapy LLC reserves the right to change the terms of this Notice and make the new Notice provisions apply to all health information MOVE Mobile Therapy LLC keeps. This includes health information MOVE Mobile Therapy LLC had prior to any change in this Notice. MOVE Mobile Therapy LLC must promptly change this Notice when there is a material change to our uses or disclosures, your rights, our duties and other related circumstances. To receive such Notices by email, you should tell the contact listed at the end of this Notice.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Federal law permits MOVE Mobile Therapy LLC to use and disclose protected health information for purposes of treatment, payment, and health care operations as those terms are defined under federal law. MOVE Mobile Therapy LLC will comply with any state or federal law that is more restrictive as to our uses and disclosures of protected health information. There are also times when federal law permits or requires MOVE Mobile Therapy LLC to use or disclose your information without your written permission. Additionally, where appropriate, MOVE Mobile Therapy LLC may disclose protected health information to a group health plan or plan sponsor in accordance with federal law.

Permitted Disclosures:
MOVE Mobile Therapy LLC may not make all of the uses and disclosures listed here, but federal law permits use or disclosure of your information without your permission:
• When MOVE Mobile Therapy LLC disclose your information to you.
• To third party non-MOVE Mobile Therapy LLC associates that perform services for MOVE Mobile Therapy LLC or on our behalf.

MOVE Mobile Therapy LLC
Ponte Vedra, FL 32081
Ph: (904) 395-5335
Fax: (904) 342-6257

HIPAA Notice of Privacy Practices for Protected Health Information

• Where disclosure is required by law.
• To a public health authority authorized by law to collect or receive your information to prevent or control disease, injury or disability or when reviewing reports of child abuse or for the conduct of other authorized public health activities and responsibilities.
• To a health oversight agency for such activities.
• For judicial and administrative proceedings.
• To a law enforcement official for a law enforcement purpose.
• To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law.
• To organ donor organizations in order to aid in such donations.
• For certain research purposes authorized by and subject to federal law.
• To avert a serious threat to health or safety.
• To government officials regarding military personnel and certain domestic and foreign government officials for certain functions authorized by federal law.
• To comply with workers' compensation and other similar programs.

Required Disclosures
MOVE Mobile Therapy LLC must disclose your information when required by the Secretary of the Department of Health and Human Services to make sure MOVE Mobile Therapy LLC complies with federal law. MOVE Mobile Therapy LLC is also required, with certain exceptions, to provide you with access to inspect and obtain a copy of your information that MOVE Mobile Therapy LLC keeps. See "Federal Law Provides You with the Right to Inspect and Copy Protected Health Information" below.

INDIVIDUAL RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION
FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS: You have the right to request that restrictions be placed on certain uses and disclosures of your information. MOVE Mobile Therapy LLC is not required to agree. If MOVE Mobile Therapy LLC does agree, MOVE Mobile Therapy LLC may not use or disclose any of your information except where you need emergency treatment. MOVE Mobile Therapy LLC may end an agreement to restrict as allowed by federal law. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION: If you choose to have your information sent to you by a means of your choice or to an address of your choice, MOVE Mobile Therapy LLC will do so if the request is reasonable. You must clearly state that disclosure of all or any part of your information could endanger you if not sent per your choice. Any such request should be

MOVE Mobile Therapy LLC
Ponte Vedra, FL 32081
Ph: (904) 395-5335
Fax: (904) 342-6257

sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION: You have the right to inspect and copy your information, certain information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure. Any request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right, even if you have agreed to receive notice by email, to get a paper copy of this Notice. All requests should be 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 complain to us by writing to the contact listed at the end of this Notice. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is also available to provide you information regarding questions you have or other information concerning this Notice.

THE CONTACT TO WHOM YOU SHOULD ADDRESS YOUR COMPLAINT IS:

Brandi Renfro, Florida PT30252
MOVE mobile therapy LLC
78 Sunburst Ct
Ponte Vedra, FL 32081
(904) 395-5335

The effective date of this notice is 01/01/2020.
Form revised 09/06/2020.

MOVE Mobile Therapy LLC
Ponte Vedra, FL 32081
Ph: (904) 395-5335
Fax: (904) 342-6257

Acknowledgment, Financial Responsibility, and Cancellation Policy

Release of Information:
MOVE Mobile Therapy LLC is authorized to release pertinent medical information to your referring physician and your insurance company regarding coverage for services performed with the patient.

HIPAA Acknowledgement:
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices as required by HIPAA.

Electronic Communication:
I agree to receive phone calls, text messages and/or email correspondence including appointment scheduling and confirmation, receipts for payment, invoices, and follow-up correspondence with MOVE mobile therapy LLC.

Guarantee of Payment/Financial Responsibility/Insurance:
Payment is due at the time of service. I agree to pay MOVE mobile therapy LLC in full at the end of each treatment session, unless otherwise agreed upon by both parties in writing. I understand that any outstanding balance is my responsibility. I agree to pay the balance within 14 days of receipt of invoice (unless a payment plan has been discussed and agreed upon). Please check one of the following:
____ I do not want receipts
____ I want a receipt after each visit
____ I want one receipt after all visits have been completed
I want my receipts by ____ email ___ US mail

Cancellations:
I understand that if I am unable to attend a scheduled appointment, I am required to cancel the appointment by email, text, or phone call to my therapist 12 hours prior to the said appointment; otherwise a fee of 50% of the agreed appointment fee will be incurred for late cancellations. This fee is required because another patient could have been scheduled and treated in this time slot.

Consent:
By signing my name below, I verify that I have read and agree to the information contained in this packet and that the information I have provided is true and accurate.

_____
Patient's signature

_____
Patient's printed name

_____
Date