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RenoNeuroFit.com

Policies & Procedures for Physical Therapy Services

Welcome to NeuroFit Wellness & Physical Therapy, LLC! We provide individualized one-on-one care through our strong belief in a holistic, whole life approach to wellness. We understand that physical health is affected by personal relationships and environmental experiences. We honor your comfort and privacy throughout your journey by creating a healing space.

The name NeuroFit encompasses our passion for mind-body wellness. Our minds are integral for the success of our physical health and in attaining our unique optimal wellness goals. We're excited to work with you!

Please review, initial, and sign these policies and procedures carefully. They govern our work together as we provide you with physical therapy services.

Communication

By providing NeuroFit Wellness & Physical Therapist, LLC with a phone number and email address below, you authorize us to leave a message at such phone number and send unencrypted emails to such address. Please know that phone and email may not be secure methods of communication.

_____ **My initials signify that I acknowledge and agree to this communication policy.**

Phone: _____ Email: _____

Notice of Privacy Policies & Procedures

We strive to comply with all federal and state medical privacy laws, which require us to protect the confidentiality and privacy of your records and personal information. We have implemented privacy policies and procedures to ensure compliance with these requirements. This information is summarized on our Notice of Privacy Practice. We

have offered this Notice and it is available on our website and upon request. Please ask if you have questions about how we protect your privacy.

_____ **My initials signify that I acknowledge and agree that I have been offered the Practice's Notice of Privacy Practice and the Notice also available on the Practice's website and upon my request.**

Payment Terms

We are not contracted with any private insurance company. This means that we do not accept or bill private insurance on your behalf for our services. This also means that as a condition of us providing services to you, you agree to pay us the full amount of the services that we provide at the time of your appointment, but you may use a Health Savings Account.

Upon request, we will provide you with the necessary documentation, so that you may submit a claim on your own to your private insurance. We do not directly submit claims or communicate with private insurers. Please check with your insurance prior to your appointment. Although rare, in some cases, your insurance company may not cover our services.

_____ **My initials signify that I acknowledge and agree that I am responsible for payment of 100% of my treatment costs at the time of service and my insurance company, if any, may not reimburse me for such services.**

Medical Records Request Policy

We maintain records about our treatment of you. To obtain a copy of your records, please submit a written request, including your full name, date of birth, date of request, and signature. Please also specify to whom you want your records sent, their address, and the reason for your request.

Please note that in some instances we may charge a reasonable and cost-based copying, postage, shipping, scanning, or digital storage device fees.

_____ **I acknowledge and agree that all records requests must be in writing, and I may be charged a cost-based fee.**

Indemnification & Assumption of Risk

As a condition of receiving physical therapy services, you agree to indemnify us against all claims, liabilities, losses, damages, suits, costs, and expenses (including reasonable attorney's fees) relating to our physical therapy services to you, unless such a claim is

caused by our gross negligence or willful misconduct. You agree to assume all risk of property damage, injury, or death associated with any physical therapy provided to you.

We will discuss all anticipated risks and benefits of, and alternatives to, your planned treatment, and you will have an opportunity to ask questions. The terms of this indemnification and assumption of risk policy shall survive the expiration date of any treatment.

_____ **My initials signify that I hereby agree to indemnify NeuroFit Wellness & Physical Therapist, LLC and its providers and assume all risk of physical therapy services.**

CANCELLATION

If you need to cancel or reschedule your appointment, please contact us at least 24 hours before your scheduled appointment to avoid a late cancellation fee. This means that if you cancel without providing us 24-hours' notice or do not come to your appointment at all, you will be charged a $30.00 cancellation fee and your insurance (if any) will not pay for this fee.

_____ **My initials signify that I acknowledge and agree that I must cancel within 24 hours of my scheduled appointment or be charged a $30.00 late cancellation fee.**

ACKNOWLEDGEMENT & AGREEMENT

I, the undersigned, hereby acknowledge and agree that:

- I have completed read and understand this document and have provided truthful information;
- I am bound by these policies and procedures;
- I shall indemnify NeuroFit Wellness & Physical Therapist, LLC, and its providers; and
- I voluntarily assume all risks of treatment.

My Name: _____ Signature: _____ Date: _____

If you are a minor (under 18 years old), please ask your parent or guardian to review this document and sign below.

I, the undersigned, am the parent or guardian of the above referenced patient. I have reviewed this document and agree to be bound by it on my behalf and on behalf of the patient.

Name: _____ Signature:_____ Date _____

For Practice use only:

Initials of reviewing provider: _____ *Date of review:* _____

Patient ( ) did or ( ) did not have additional questions about these policies.

*Notes:*_____

Informed Consent for Physical Therapy

Prior to us treating you with physical therapy services, you must provide informed consent to receive physical therapy services. You can only provide us with your informed consent after we have discussed our proposed treatment, the potential risks of those treatments, the potential benefits of those treatments, and information about any potential alternative treatments.

Therefore, I, the undersigned, acknowledge and agree that NeuroFit Wellness & Physical Therapist, LLC and its providers will render the below described physical therapy services:

To Be Completed Together During Our First Visit.

1) Brief summary of description of physical services that we will provide.

2) Brief summary of description of the potential material risks, benefits, and alternative treatments

Acknowledgement & Agreement

- As provided above, my physical therapist has explained the services and treatments that I will receive, as well as their material risks and benefits.
- I agree and acknowledge that treatment and services may not have the results that I expect or desire. My physical therapist has discussed with me other possible treatments that might provide me a benefit.
- I Agree and acknowledge that physical therapy is not an exact science, and I have not been given any guarantees about treatment.
- My physical therapist has offered me ample time and opportunity to discuss my concerns, and all of my questions have been answered to my satisfaction.

My Name: _____ Signature: _____Date: _____

If you are a minor (under 18 years old), please ask you parent or guardian to review this document and talk with us and sign below. I, the undersigned, am the parent or guardian of the above referenced patient. I have reviewed this document and agree to be bound by it and hereby provide my informed consent for treatment of the patient on my behalf and on behalf of the patient.

Name: _____ Signature:_____ Date _____