SUTTON HEALTH ADVOCACY
Pelvic Physical Therapy

Consent Forms for Physical Therapy

Section 1: Informed Consent to Treatment

I hereby consent, by my own free will, to voluntarily engage in an in-person visit or the virtual/ telehealth session, through telephone or video conferencing, by a licensed physical therapist. The physical therapist will explain the nature and purposes of procedures, evaluation, and course of treatment. Recommendations will be made by my therapist to improve my condition and overall wellness. A physical therapy diagnosis is not a medical diagnosis by a physician. Any recommendations that my physical therapist makes can have potential risks and benefits. I may not get immediate relief of symptoms and may even have an aggravation of symptoms. I will honestly report my symptoms to my physical therapist so that she can best guide my treatment. I can decline any suggested treatment and also stop any treatment at any time. My therapist will make every effort to address my symptoms, functional deficits (if any), and concerns and that the goal is for total alleviation of symptoms and/ or improvement of function. Even with the best program there is a possibility that I may not notice changes or improvements. I recognize that these sessions will allow me to learn ways to move better, feel better, and teach me techniques and skills that I can utilize independently on a daily basis and improve my quality of life. I am aware that addressing my symptoms or diagnosis may take a few sessions and I am required to closely follow all provided instruction to ensure improvements within at least 4-6 sessions (if not sooner). The number of sessions will vary based on the primary complaints and symptoms and that this reference serves as an average and not a definite number.

Section 2: Financial Responsibility

I understand that I am 100% responsible for payment, due at time of scheduling. NO insurance in any form will be billed, charged, or collected for these sessions. I choose by my own free will to participate and invest in this service.

Section 3: Cancellations and Missed Appointments

In the event that the patient is unable to keep an appointment, please contact your therapist as quickly as possible. Visits that are not canceled **at least 24 hours prior to visit time** or are not canceled at all will be billed **50% of the cost of the missed appointment.** E-mail, text message,

and phone are suitable means to communicate visit cancellation. In the case of a true medical emergency or sickness, the cancellation fee will be waived.

Section 4: Privacy Policy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up amount the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Conduct normal healthcare operations such as quality assessments and physician certifications.

3. Obtain payment from third-party payers.

I have been informed by Sutton Health Advocacy LLC of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Sutton Health Advocacy has the right to change the Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Sutton Health Advocacy LLC restricts how my private information is used or discussed to carry out treatment, payment or health care operations. I also understand that Sutton Health Advocacy LLC is not required to agree to my requested restrictions, but if the owner does agree than she is bound to abide by such restrictions.

I understand that I Amy revoke this consent in writing at any time, except to the extent that Sutton Health Advocacy LLC has taken action relying on this consent.

Section 5: Concerns and Complaints

If the patient is concerned that Sutton Health Advocacy LLC or its employees have violated privacy rights or if the patient or caregiver disagrees with any decisions that have been made,

please contact the Executive Counsel of Physical Therapy and Occupational Therapy Examiners at https://www.ptot.texas.gov.

Section 6: Consent to Email / Text for Appointment Reminders or Healthcare Matters

Patients in this practice may be contacted via e-mail and / or text messaging to be reminded of an appointment, to obtain feedback on their experience with this healthcare team, and / or to provide general health reminders / information. If at any time I provide an e-mail or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications / information at that e-mail or text address from Sutton Health Advocacy LLC staff. I understand that I may revoke this consent at any time by contacting support@suttonhealthadvocacy.com.

Section 7: Consent for Comments (Not Name) To Be Used in Marketing Materials

I consent for any comments I email or text to be used in marketing materials. I understand my real name will be concealed and a moniker will be used in place of my real name.

Section 8: Travel Fee

I understand that there is a travel fee associated with each home visit of $75.00. I agree to pay this travel fee.

Section 9: COVID Policy

I consent to be screened at the beginning of an in-person session for symptoms of COVID-19. You may be required to provide a copy of your COVID-19 Vaccination Record Card prior to your first appointment. I consent to wear a face mask or face covering over my nose and mouth throughout the entire duration of my visit. If any other people will be present during in-person sessions, they will also wear a face covering or face mask or remain further than 6 feet away from the treating therapist.

Section 10: Direct Access Disclaimer

Should I choose to partake in physical therapy without a referral from a physical, I understand that an evaluation by a Physical Therapist is not a medical diagnosis by a physician. I understand that I can be seen for up to 15 days without a referral from a physician or qualified healthcare practitioner (chiropractor, dentist, podiatrists, physician assistant, and/or advanced nurse

practitioner including certified nurse midwives). If I choose to remain in physical therapy longer than 15 days, I understand I will need to obtain a referral for physical therapy services from my physician or qualified healthcare practitioner.

Signature

By clicking “I have read, agree with, and understand the above statements” on the question located on the Sutton Health Advocacy intake form, located at: https://docs.google.com/forms/d/1QyJOnGfmRhbBo0DZvnLduXcTYgrT4l2w6-Fhk2mKF4M/edit, I consent that I have read, agree with, and understand the above statements and consent to physical therapy evaluation and treatment under these terms.