Ally Physical Therapy GENERAL CONSENTS AND ACKNOWLEDGEMENTS

Dear Patient,

By signing this form, I, the undersigned, consent to the evaluation and treatment procedures for my physical therapy care at Ally Physical Therapy as prescribed by my healthcare providers. I acknowledge the following terms and conditions associated with my treatment:

1. **Authorization for Care and Treatment**: I consent to and authorize the physical therapy evaluation, care, and treatment that are deemed necessary by my physician(s) and healthcare providers, including any procedures or modalities that may be used during my treatment. I understand that no warranties or guarantees have been made regarding the outcome or success of my treatment.
2. **Liability for Personal Property**: I understand that Ally Physical Therapy (or the treating clinic) will not be responsible for any loss, theft, or damage to my personal property while on clinic premises. I assume full responsibility for my personal belongings and release the clinic from any liability related to their loss, theft, or damage.
3. **Leased Property and Release of Liability**: I acknowledge that Ally Physical Therapy may lease or license equipment or property used in the provision of services. In consideration of accessing and using such property, I, on behalf of myself and any minors or individuals under my care, release and discharge the owners, employees, agents, and affiliates of the leased property from any liability for claims arising from injuries, losses, or damages, except those caused directly by Ally's negligence.
4. **Right to Refuse Treatment**: I have the right to ask questions regarding the planned treatment, including the risks and benefits, and to decline any portion of the treatment at any time during the course of my therapy. I acknowledge that physical therapy involves various physical risks, including but not limited to pain, injury, or aggravation of pre-existing conditions.
5. **Recording and Photography Policy**: I understand that I am not permitted to take photographs, make video or audio recordings of my treatment, or any other aspect of my care at the clinic. I agree to respect the confidentiality of all individuals within the clinic and will not record any treatment sessions without prior authorization.
6. **Monitoring and Communication**: I understand that phone calls, including those between myself and Ally PT or its affiliates, may be monitored or recorded for quality assurance and training purposes. Additionally, I consent to receiving communications from Ally PT, including calls, text messages, and emails related to my treatment, appointment reminders, and other relevant information. These communications may be made using pre recorded messages or automatic dialing systems. I understand that consent for these communications is not required as a condition of receiving services, and I may revoke this consent at any time.
7. **Appointment Scheduling and Cancellation Policy**: I acknowledge that my appointments are scheduled based on the availability of professional staff. If I arrive more than 15 minutes late for an appointment, my session may need to be rescheduled. I also understand that Ally PT requires 24 hours' notice for any appointment

cancellations and that failure to provide such notice may result in a $45.00 cancellation fee.

8. **Physical Therapy Procedures**: I understand that physical therapy involves procedures that may include the touching of my body by my therapist or other professional staff, and in some cases, partial or full disrobing may be necessary for effective care. I consent to such touch as part of the therapeutic process and understand that my comfort and privacy will be respected at all times.
9. **No Guarantee of Results**: I recognize that physical therapy is both an art and a science. As such, no guarantees can be made regarding the outcome or success of any treatment. I acknowledge that the response to physical therapy treatment can vary, and while therapy may improve function and alleviate symptoms, the results cannot be guaranteed.
10. **Financial Responsibility**: I agree to cooperate fully with my therapist and comply with the prescribed plan of care. I understand that I am responsible for the payment of all charges for services rendered, including applicable co-pays, co-insurance, and any additional charges that are not covered by my insurance. I will make prompt payment as required and upon receipt of the clinic's invoice.

By signing below, I confirm that I have read and understood the contents of this form, had the opportunity to discuss any questions with my therapist, and voluntarily consent to receive the physical therapy treatment described herein. I further understand that I may withdraw my consent or request modifications to my treatment plan at any time.

Patient Name: _____
Patient Signature: _____
Date: _____

If the patient is a minor, the following must be completed by the parent or legal guardian:

Name of Responsible Party/Guardian:
_____
Signature of Responsible Party/Guardian:
_____
Date: _____

Ally Physical Therapy NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION

Certainly! Below is a reframed version of the document, using professional terminology and ensuring compliance with HIPAA standards:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Legal Duty to Protect Health Information: Ally Physical Therapy is committed to protecting the privacy and confidentiality of your personal health information as required by law. This notice outlines our information practices and our obligations under the Health Insurance Portability and Accountability Act (HIPAA). We are required to follow the practices described in this notice.

Uses and Disclosures of Health Information:

Ally Physical Therapy uses your personal health information primarily for the following purposes:

1. **Treatment:** To provide, coordinate, and manage your care and treatment.
2. **Payment:** To obtain payment for the services provided to you, including billing and insurance-related activities.
3. **Administrative Purposes:** For internal operations, such as quality assessment, training, and administrative purposes.
4. **Health-Related Communications:** To inform you of appointments, account status, or treatment alternatives that may be of interest to you.

   In addition, Ally Physical Therapy may use or disclose your health information without your prior written authorization for the following purposes:

- **Public Health and Safety:** For reporting purposes related to public health, such as preventing or controlling disease or injury, or for notifying individuals of potential exposure to communicable diseases.
- **Research:** As permitted by law for research studies (without including personally identifiable information such as your name or social security number).
- **Auditing and Legal Compliance:** For internal audits and compliance with applicable laws.
- **Emergencies:** In emergency situations where disclosure is necessary to protect your health or safety.

In any situation not covered above, Ally Physical Therapy will seek your written authorization before disclosing your personal health information. You have the right to revoke your authorization at any time, which will stop future disclosures (except where we have already relied on your authorization).

Ally Physical Therapy reserves the right to change its privacy practices and update this notice as needed. Any changes to our privacy practices will be posted in a common area of our facility. You may also request a copy of the updated notice at any time.

Patient's Rights Regarding Personal Health Information:

As a patient, you have the following rights regarding your personal health information:

1. **Right to Access:** You have the right to request access to and obtain a copy of your health information.
2. **Right to Amend:** You may request that we amend any inaccurate or incomplete information in your health records.
3. **Right to an Accounting of Disclosures:** You may request a list of disclosures of your personal health information, excluding those made for treatment, payment, or administrative purposes.
4. **Right to Request Restrictions:** You may request in writing that we restrict the use or disclosure of your personal health information for treatment, payment, or administrative purposes, except where required by law or in emergency circumstances. Please note that while we will consider your request, we are not legally obligated to accept it.

Concerns and Complaints: If you believe your privacy rights have been violated or if you disagree with any decisions made regarding the access or disclosure of your personal health information, please contact our office at the address below. You may also file a formal complaint with the U.S. Department of Health and Human Services.

Ally Physical Therapy Financial Policy:

By signing below, you acknowledge that Ally Physical Therapy - Livonia verifies your insurance benefits as a courtesy, but it is ultimately your responsibility to understand your insurance coverage and benefits. Although we will attempt to confirm your benefits, this verification is not a guarantee of payment. If your benefits do not cover the full number of visits or services provided, you will be responsible for any charges exceeding your coverage. Many insurance plans aggregate visits for physical therapy, speech therapy, occupational therapy, and chiropractic care, which may impact your available visit limits. We strongly encourage you to contact your insurance provider directly to confirm your benefits and visit limits. If you have utilized PT/OT/SPEECH OR CHIRO services at any other facility, it is your responsibility to track the number of visits used and inform our office with an accurate count. Failure to report this information may result in you being responsible for any charges exceeding your benefits. You are also responsible for providing accurate insurance information; if your insurance denies coverage due to incorrect or incomplete information, you will be liable for all charges, and payment is due within 30 days of claim rejection. Any co-pays, co-insurance, DEDUCTIBLES or out-of-pocket expenses required by your insurance plan are due at the time of service. If we are a participating provider with your insurance, we will accept the contracted amount for covered services, but you are still responsible for your portion. Any services deemed non-covered by your insurance but considered necessary by your care team will be discussed with you prior to implementation. You will be responsible for the full payment of non-covered services at the time they are rendered. If another party (such as auto insurance, workers' compensation, or a legal case) is responsible for covering your therapy costs, you must provide all necessary information for us to bill them directly. If your insurance initially pays for services, and it is later determined that another party should cover the costs, we will work with them to recover the funds. If the responsible party fails to make payment, we will revert to your insurance, and if your insurance does not cover the services, you will be liable for the charges. Payment and delinquent balances such as Deductibles, co-insurance Co-pays and other charges are due at the time of service.If you have an outstanding balance, and reasonable efforts to collect the amount due have been made, we may use the payment information on file (such as credit card or bank account information) to settle your balance. We accept cash, credit cards and checks.If your services are covered by an out-of-network insurance plan or a third party, we will bill the responsible party directly. If your insurance sends payment to you instead of directly to us, you are required to forward the payment along with the signed check and Explanation of Benefits (EOB) to our office within 72 hours. Failure to do so will result in you being liable for any unpaid charges. For minors (under 18), the parent or guardian signing this form accepts full responsibility for all financial obligations, including co-pays, co-insurance, and any other charges. The parent or guardian is also responsible for providing accurate insurance information, and any outstanding balances for services rendered will be their responsibility.

By signing below, you confirm that you have read, understood, and agree to the terms outlined in this financial policy, and you accept responsibility for any charges incurred for services rendered at Ally Physical Therapy - Livonia.

Signature: _____
Date: _____

ALLY PHYSICAL THERAPY HIPAA Authorization to Medical Records and Billing Information

I hereby authorize the following individuals and/or entities to request and receive any protected health information regarding my treatment, including medical records, appointment times, billing records, and any other information related to my treatment at Ally Physical Therapy - Livonia.

Note: Please list any attorneys, family members (e.g., siblings, spouse), doctors (other than the prescribing physician), or other individuals who may need access to your medical records or billing information.

	Name	**Relationship**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

I understand that I am not required to list any individuals on this form, but I am granting them permission to receive protected health information and/or billing information about my treatment. I also acknowledge that this authorization may be revoked at any time by providing written notice to Ally Physical Therapy.

By signing below, I confirm that I have provided the names of individuals who are authorized to receive my medical and billing records and understand my rights under HIPAA.

Patient Name: _____

Signature: _____ **Date:** _____

If the patient is a minor, the legal guardian must sign below to authorize the release of the minor's medical and billing information

Legal Guardian's Name (if applicable): _____

Relationship to Patient: _____

Legal Guardian Signature: _____**Date:**_____

ALLY PHYSICAL THERAPY LLC.
EMPOWER YOUR HEALTH

Patient Medical History and Screening Questionnaire

Patient Name: _____ **Date of Birth**: _____ **Sex**: F M

What is your main complaint and area located? _____

Have you ever had these symptoms before? Yes____ No____ If yes, When? _____

Have you had Physical Therapy, Occupational therapy or Chiropractor care for this injury? Y N Which one and When? _____

Have you received Home Health Care this year? Y N, If so, When_____

Occupation: _____ Are you presently working? Y N If No, Last date worked_____

Do you Smoke/ use Tobacco? Y N Do you exercise regularly? Y N, if Yes _____days/week

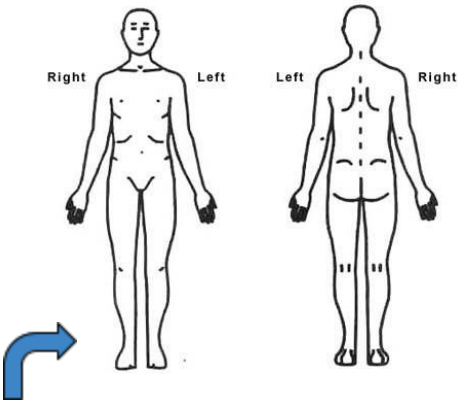
Check all that apply to your current condition:

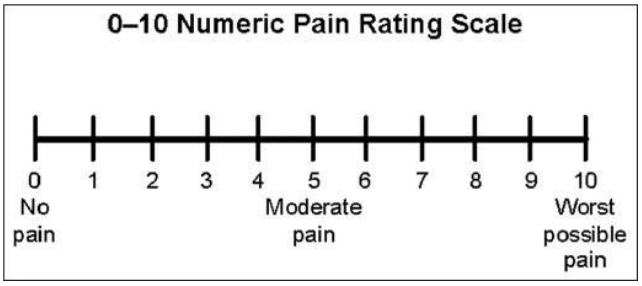
( ) Work Related Injury ( ) Sports Injury ( ) Fall ( ) Motor Vehicle injury ( ) Injury recurrence

( ) Aggravation of Pre- Existing Injury ( ) Causes Unknown ( ) Other _____

What is the **Date of Injury** or date (approx.) your symptoms started? : _____

Are you symptoms getting worse/better/ the same since your injury? _____





Mark the areas you have Pain on the body chart **Circle the current level of pain on the scale**

P: Pain **T**: Tingling **N**: Numbness Pain level at Best (0-10) _____

B: Burning **C**: Cramping **S**: Shooting Pain level at worst (0-10) _____

What activities **aggravates** your pain? _____

What activities **eases** your pain? _____

Check any of the following activities are difficult to perform due to your injury?

( ) Housekeeping ( ) Lifting ( ) Driving ( ) Shopping ( ) Reaching ( ) Dressing ( ) Cooking

( ) Sit to stand ( ) Climbing Stairs ( ) Child care ( ) Bending ( ) Yard work ( ) Sports

Circle if you have any tests performed? X-ray MRI CT Scan Bone Scan Other _____

TURN OVER

32858 5 Mile Rd, Livonia, MI 48154 Ph no: 7345253000 Fax: 7345253001

Medical History and Screening questionnaire contd.

Allergies: Are you allergic to any medications? (Please list)_____

Do you have a **Pacemaker**? Y N Are you **Latex sensitive**? _____

For Women: Are you pregnant or think you might be pregnant? Y N

Have you recently noted any of the following (check all that apply)?

( )Fatigue ( )Fever/chills/sweats ( )Nausea/vomiting ( )Unexplained weight loss/gain

( )Frequent Falls ( )Muscle weakness ( ) Impaired balance ( )Dizziness/lightheadedness

( )Headaches ( )Heartburn/Indigestion ( )Changes in bladder function ( )Changes in bowel function

( )Diarrhea ( )Constipation ( )Cough ( )Shortness of breath

Have you ever been diagnosed with any of the following conditions (Check all that apply)?

( )Cancer ( ) Heart Diseases ( )Chest pain ( )Circulation problems

( )Diabetes ( ) Hypoglycemia ( )High blood pressure ( )Aids/HIV

( )Asthma ( ) Respiratory problems ( )Stroke ( )Multiple Sclerosis

( )Osteoarthritis ( )Rheumatoid Arthritis ( )Bone/joint Infection ( )Osteoporosis

( )Fibromyalgia ( ) Bladder Problems ( )Kidney Disease ( )Liver Disease

Please list all Current Medications: _____

_____

Have you ever taken blood thinning or anticoagulant medications for any medical condition? Y N

Have you been recently hospitalized? (Provide with dates and reason)_____

Past Surgical History (List all and date):_____

_____

Depression Questionnaire:

During the past month have you been feeling down, depressed or hopeless? Y N
During the past month have you been bothered by having little interest /leisure in doing things? Y N
Is this something with which you would like help? YES YES, BUT NOT TODAY NO

What are your goals in Physical Therapy? _____

_____

Acknowledgement: By signing this document, I certify that information provided by me is accurate, complete and to the best of my Knowledge.
Patient/Parent/Guardian/Authorized Representative Signature: _____ Date: _____
If not signed by the patient, please indicate relationship to the patient_____
Therapist Signature: _____ Date: _____

Ally Physical Therapy Appointment Cancellation and Attendance Policy

To ensure that we provide the best possible care to all of our patients, we require a 24-hour notice for any appointment cancellations. If you cancel an appointment without providing 24 hours' notice, a $45 cancellation fee will be charged. However, if you reschedule a makeup appointment within the same week and do not cancel any other appointments that week, the cancellation fee will be waived.

Please note that if you cancel three (3) appointments without giving 24 hours' notice, Ally Physical Therapy - Livonia reserves the right to discontinue your treatment at our discretion.

We also ask that you arrive on time for your appointments. If you are late for your scheduled appointment three (3) or more times, we may be required to discontinue your treatment at our facility.The time allocated for your appointment is dedicated specifically to you. Please respect our clinicians' time, as cancellations or lateness can disrupt their schedule, your care and hinder your progress.

By signing below, you confirm that you have read, understood, and agree to the terms of this policy. You also acknowledge that all of your questions have been answered to your satisfaction.

Patient Name: _____
Patient Signature: _____
Date: _____