Patient Consent/Refusal Form

Patient Name: _____

Patient Email Address: _____ Date of Birth ____ / ____ / ____

Purpose: To obtain your consent to participate in In-Person/Telehealth Consultation/Treatment. This notice also describes how medical information about you may be used and disclosed. Please review it carefully.

Interventions may include but are not limited to: patient evaluation; discussion of patient condition; how to manage symptoms; visual assessment of movement patterns; therapeutic activities; therapeutic exercises; neuromuscular re-education; manual therapy; patient/ caregiver education/training; modalities; and education on home exercise program.

1. During the In-Person/Telehealth Consultation:

A. Review patient history, medical records, screening tools, examinations, follow up appointments, wellness programs, results of imaging, and test may be discussed with health care providers through the use of interactive video, audio and telecommunication technology
B. A digital, physical examination may be performed
C. A non-medical technician for either party may be present to assist in providing services through video transmission or in-person
D. Photo, video, and/or audio recording may be taken with the purpose to facilitate the procedure(s) and service(s) provided

2. Medical Information and Records: We may use medical information about you to provide medical treatment or services. You are also giving us permission to reach out to other health providers or those providing care to you to assist proving health services to you while participating in services with us. We may use and disclose health information about you for operations of this health care practice. Some but not all in-person/telecommunication services and assessments may be recorded and stored. Additionally, the dissemination of any patient identifiable images or information for this consultation to other groups or entities will not occur without your consent. To Avert a Serious Threat to Health or Safety: we may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Your Right to Inspect and Copy: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. Printed copies of your records will incur a clerical cost of $15.00 plus .25 per age.

3. Confidentiality: Appropriate and reasonable effort to minimize confidentiality risks associated with in-person/telehealth consultation have been made by this provider and you agree to accept these services. By signing this form, you also confirm that this is a private email with a personal password that is known only to you and will be used to communicate personal and private information.

You are giving us permission to disclose information as needed to assist in your overall health treatment, general safety of yourself and others, and as required by law. For individuals involved in your care or payment for your care: we may release medical information about you to a friend or family member who is involved in your medical care. As required by Law: we will disclose medical information about you when required to do so by federal, state, or local law. For military and veterans: if you are a member of the armed forces, we may release medical information about you as required by military command authorities. For Worker's

Compensation: we may release medical information about you for worker's compensation or similar programs. For Public Health Risks: we may disclose medical information about you for public health activities. For Health Oversight Activities: we may disclose medical information to to a health oversight agency for activities authorized by law. For lawsuits and disputes: If you are involved in a lawsuit or a dispute, we may disclose information about you in response to a court or administrative order. We may also release medical information to law enforcement, coroners, medical examiners, federal officials authorized by law. For inmates: if you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution or law enforcement official.

4. Social Media Disclosure: I understand that information can be used on social media platforms. Verbal or written consent will be obtained before using any video or information related to your treatment in order to produce such content.

5. Consent for Calls and Texts: Client agrees to accept calls or texts on any phone number provided, for any purpose, including via Automatic Telephone Dialing System and/or artificial or pre-recorded voice, and that such consent is not a condition of any good or service.

6. Disputes:
Arbitration Agreement: Except for any dispute related to medical malpractice (which shall be governed by the Patient-Provider Arbitration Agreement form provided upon request), I understand and agree that any and all claims arising from or relating to this Agreement or any service provided by Neil Taing, PT, DPT to you shall be subject to binding arbitration under the Federal Arbitration Act ("FAA"). This includes claims based on contract, tort, equity, statute, or otherwise, as well as claims regarding the scope and enforceability of this provision. It includes all claims by or against me and others providing or receiving any product or service related to this Agreement. A single Arbitrator shall decide all claims and shall render a final, written decision. You may choose the American Arbitration Association ("AAA"), Judicial Arbitration and Mediation Service ("JAMS"), or other similar arbitration service provider acceptable to Neil Taing, PT, DPT to administer the arbitration. Consistent with the FAA, the appropriate AAA rules, JAMS rules, or other service provider rules shall apply, as determined by the Arbitrator. For AAA and JAMS, these rules are found at www.adr.org and www.jamsadr.com. Unless otherwise agreed by the parties, the arbitration shall take place in Los Angeles, California. Each party to the arbitration shall pay his, her, or its own costs of arbitration. If you cannot afford your arbitration costs, you may apply for a waiver under the relevant rules.

Class Action Waiver: The parties waive any right to bring representative claims on behalf of a class of individuals, on behalf of the public, as a private attorney general, or otherwise (the "class action waiver"). Except for this class action waiver, this clause may be severed or modified if necessary to render it enforceable under the FAA.

Governing Law: This Agreement shall be governed by the laws of the State of California, without regard to its conflicts of law rules. The provisions of this Agreement shall be severable, and if any provisions shall be prohibited by law, or invalid, or unenforceable in whole or in part for any reason, the remaining provisions shall remain in full force and effect. No party hereto shall be considered to be the drafter of this Agreement or any paragraph or term hereof and no presumption shall apply to any party as the "drafter."

7. Payment: You understand and are responsible for full payment of services provided by this out-of-network provider. You understand that you may be able to contact your insurance provider for reimbursement for services provided through these services. You are required to pay fees before treatment is provided unless otherwise discussed with this physical therapist.

I understand and acknowledge that services provided by Neil Taing, PT, DPT are not paid for or reimbursed by managed care plans, Medicare, Medicaid, commercial health insurance, or any other third-party payor programs and we do not accept insurance for services.

8. Cancellation & No-Show Policy: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $40.00 for physical therapy visit and/or full price.

9. Changes of This Notices: We reserve the right to change this notice and will verbally inform you of such changes. You have the right to request a printed copy as well.

10. Risks, Consequences & Benefits: You have been advised and understand the possible risks, outcomes, and benefits in participating in telehealth. You are aware of possible alternatives to physical therapy intervention as well. A health care provider has appropriately disclosed this information provided in this document, and you are choosing to consent to services provided.

A. Potential Risks: As with any medical interventions, there are inherit risks involved. These risks may include but are not limited to technical difficulties/insufficient information transfer (i.e. poor connection and limited screen resolution) that could subtract from appropriate decision making, unauthorized access, inability for health care providers to provide physical medical treatment or emergency care, typical risks involved with physical activity (i.e. increase in heart rate and potential falls), and possible risks of aggravating symptoms (which are usually temporary).

B. Potential Benefits: Improving access to medical care from the comfort and safety of your home or chosen location, distant access to a health care provider, a focus on education to teach you how to manage your symptoms independently, continued expert consultation, possible improvement in symptoms and ability to perform daily activities, improved overall quality of life.

11. Rights: You have the right to withhold or discontinue your consent to in-person/telehealth consultation at any time. Any charges paid may or may not be refunded based on the situation. You understand that the health care provider also has the right to terminate services if deemed appropriate at any time.

By signing this form:

I agree and consent to participate in in-person/telehealth care with Neil Taing, PT, DPT and/or service(s) and procedure(s) discussed in this document. I have read, had this form read to me, and/or had this form explained to me. I understand the contents of this document. I was provided an opportunity to ask questions and any questions have been answered satisfactorily.

Signature: _____ Date _____ / _____ / _____

If not signed above by the patient receiving services, indicate the relationship:

_____ Date _____ / _____ / _____

Witness Signature: _____ Witness Name in Print_____