Grounded Physical Therapy
Shelby Donald, PT
562-294-5025

WAIVER AND RELEASE OF LIABILITY

I, _____ (herein "**Participant**"), hereby acknowledge and agree to the following, as a condition of participation in physical therapy (the "**Activities**") hosted by Grounded Physical Therapy ("**GPT**").

1. I have voluntarily agreed to participate in the in the Activities, which may be physically and mentally challenging, stressful and which may include, but are not limited to, engaging in physical activities with which I may or may not have had any prior familiarity and/or experience.

2. I understand that there is a risk of danger, bodily harm, injury, and emotional stress as a result of my participation in the Activities. I knowingly assume the risk of such injury, including the possibility of death, in connection with the Activities, regardless of who is at fault.

3. I understand that there is the potential for risks and dangers that may not be obvious or reasonably foreseeable at this time.

4. I warrant and represent that I do not have any undisclosed medical ailments, physical limitations, or mental disabilities that will affect my ability to participate in the Activities. I am not under the influence of alcohol or drugs that will affect my ability to participate in the Activities.

5. I understand that GPT, nor any of its affiliates or representatives (the "**Released Entities**"), undertake any direct or indirect legal or financial responsibility for my personal safety or wellbeing when I am participating in the Activities.

6. **I ASSUME ALL RISKS OF PARTICIPATING IN THE ACTIVITIES, INCLUDING, BUT NOT LIMITED TO, THOSE OUTLINED IN SECTIONS 1, 2 AND 3 OF THIS WAIVER AND RELEASE OF LIABILITY.** I understand and agree that I am 100% liable for all medical or other expenses incurred as a result of any injury or property damage.

7. I, for myself and my heirs, administrators, and successors and assigns, forever release the Released Entities and their respective partners, employees, officers, representatives, agents and affiliates from any and all claims and causes of action that I or my representatives now have or may have in the future for personal injury, property damage, wrongful death, or any other claims arising out of or relating to my participation in the Activities.

8. In the event that any one or more of the provisions of this Waiver and Release of Liability shall be held to be invalid, illegal, unenforceable or in conflict with the law according to the jurisdiction of the state of California, the remaining portions will not be invalidated, and shall remain in full force and effect. This is a legally binding contract, but it is not meant to include any claims or defenses that are legally prohibited.

9. The undersigned agrees that the foregoing terms **ARE INTENDED TO BE AS BROAD AND INCLUSIVE AS IS PERMITTED BY LAW**. The terms hereof shall continue **FROM THIS DATE FOREVER**. This document embodies the entire agreement and supersedes any previous or contemporaneous negotiations or agreements with respect to these matters. The undersigned agrees that no promise or inducement has been offered except as herein set forth, and that this document has not been executed based upon statements by any person other than those set forth herein.

I HAVE READ THIS WAIVER AND RELEASE OF LIABILITY, I FULLY UNDERSTAND ITS TERMS, AND I RECOGNIZE THAT I HAVE GIVEN UP RIGHTS BY SIGNING IT, IN CONSIDERATION OF MY BEING PERMITTED TO PARTICIPATE IN PHYSICAL THERAPY. I SIGN IT FREELY, VOLUNTARILY AND WITHOUT ANY INDUCEMENT.

Signature:_____ Date: _____

Name: _____ (Please Print)

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Therapy Contract

Patient's Name:_____

Please initial that you agree to the following:

____**Consent**: I consent to and authorize Shelby Donald, PT of Grounded Physical Therapy (GPT) to complete physical therapy evaluation and treatment. I understand that sometimes my treatment sessions will be conducted by an associate such as a physical therapy assistant. I understand and am informed that physical therapy may have some risks; pain or discomfort following treatment is possible. I understand that I have the right to ask about these risks and have the right to have questions about my conditions answered prior to treatment.

____**Liability:** I release Shelby Donald, PT of (GPT) and all covered entities from liability if my condition worsens. I will notify Shelby Donald, PT immediately if my symptoms worsen. I will not hesitate to seek medical attention under the advice of my physical therapist or physical therapy assistant.

____**No Guarantees**: I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by (GPT).

____**Health Updates**: I know it is up to me to inform (GPT) about any health problems, allergies, changes to health status and medications I am taking.

____**Release of Information**: (GPT) will not release my information to any third party sources without express permission. See HIPPA Consent form.

____**Collections**: All payments will be collected immediately after therapy services in the form of cash, check, on-line via invoice or Square. Receipt will be emailed, please fill out appropriate email on HIPPA form.

____**Out of Pocket:** I understand that (GPT) is a cash-based business. If I want to utilize my insurance benefits I will request a Superbill for my services. I will submit for reimbursement on my own time. Any payment that Insurance returns to me will be my own to keep as cash payment has already been collected by (GPT) day of service.

____**Cancellations**: (GPT) understands life happens. I understand that I will give Shelby Donald, PT or my treating therapist at least 24 hours to cancel my session in the form of email, call or text. Not doing so will result in a $25 cancellation fee. Three cancellations in a row will cause a termination in patient and provider relationship.

____**Minor Patients**: The parent or guardian accompanying a minor is responsible for payment of services. Parent or Guardian is not required to stay for duration of therapy session, but must be available by phone for duration of session in case of medical emergency.

The undersigned Patient or Responsible party acknowledges that he/she has read and agrees to the information printed above.

Name: _____ Date: _____/____/_____

Medical Information Release Form (HIPAA Release Form)

Grounded Physical Therapy
Shelby Donald, PT
562-294-5025

Name: _____

Release of Information

Please check all that apply

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me. This information may be released to:

Spouse_____[ ]

Child(ren)_____ [ ]

Coach_____[ ]

Other_____[ ]

[ ] Information is NOT to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Communication

Please call [ ] my home [ ] my work [ ] my cell Number:_____

[ ] Email me** Email:_____

** Email will be used for treatment reminders, receipts, home exercise program and newsletters. Your email address will not be provided to a 3rd party. You may opt out of email correspondence at any time.

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____/____/____

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New Patient Intake

Name:_____

Age:_____ DOB:_____

Today's Date_____

Occupation:_____

Roles:_____

Currently working: *yes/no*

What brings you to therapy:_____
_____
_____
_____
_____

Have you had any treatments for this condition:_____
_____
_____

Have you been treated by a doctor for this condition? *Name and address of physician:*
_____
_____

Date of Injury:_____

Date of Diagnosis:_____

How long have you had symptoms:

Days_____ Mos_____ Years_____

What are current limitations:_____
_____
_____

Current Activity level: *none/low/moderate/high*

Prior level of function:_____
_____
_____
_____

Hobbies:_____
_____

Goals:_____
_____

Are you in Pain?

At Rest *0 1 2 3 4 5 6 7 8 9 10*

At Worst *0 1 2 3 4 5 6 7 8 9 10*

Do you have pain at night?

Does pain wake you?

What makes your problem worse:_____
_____

What makes your problem better:_____
_____

Recent Imaging: *X-ray, CT scan, MRI*

Dates:_____

Any diseases run in your family:_____

PreviousSurgeries:_____
_____
_____

Medical History: please circle if YES

Heart disease	Kidney disease	GI disease
Diabetes	Liver disease	Bleeding disorder
Low vision	Low hearing	Cancer
Pregnant	Vaginal birth	Cesarean section