Stay In Step
Spinal Cord Injury Recovery Center
10500 University Center Drive Unit 130
Tampa, FL 33612
Phone: 813-977-7999
Fax: 813-977-7444
Email: diosa@stayinstep.org

CLIENT APPLICATION FORM

The information obtained in this application will remain confidential. It will be used solely by the staff of the Stay in Step Spinal Cord Injury Recovery Center (SIS) in determining program eligibility.

CLIENT INFORMATION

Name:	

Date:		Address:	
SSN:		City:	
DOB:		State:	
Email:		Zip:	
Prim. Phone:		Emer. Contact:	
Alt. Phone:		Relationship:	

MEDICAL INFORMATION

Date of Injury:		Height:	
Cause of Injury:		Weight:	
Level of SCI:		Current Rehab Program:	
Complete/Incomplete:		Physician's Name:	

Describe your physical abilities:

Upper extremity: _____

_____

_____

Trunk (IE: Can you sit up?): _____

_____

_____

Lower Extremity: _____

_____

_____

Please list any physical problems:

Disorder	Yes	No
Hypersensitivity		
Osteoporosis/ Osteopenia		
Pressure Sores/ Skin Breakdowns		
Heterotrophic Ossification		
Joint/ Muscle disorder		
Obesity		
Knee instability		

Briefly explain Event(s) Leading to Injury: _____

_____

_____

Briefly explain unlisted symptoms:

_____

_____

Please list all current medications to include: dosage, frequency and function:

MEDICATION LIST

_____

_____

_____

_____

_____

_____

_____

_____

SPECIAL CONSIDERATIONS

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Please answer "yes" or "no" for the following. Please answer "yes" to those that apply to you at present or have applied to you in the past, with a brief explanation in the space provided.

History	Yes	No	Explanation/Frequency
Alcohol			
Tobacco			
Diabetes			
High Cholesterol			
Chest Pain			
Hypertension			
Obesity			
Muscle Tension			
Hypothyroidism			
Hernia			
Breathing/Lung Problems			
Heart Disease			
Ventilator Dependent			
Tendon/Joint Problems			

Are you aware of any disease or disorder that would complicate your participation in an intense exercise program?

_____

_____

Are you currently involved in any recreational physical activities?

_____

_____

Has your physician approved your participation in an intense exercise program?

Yes _____ No _____

NOTE: Written approval by your physician is a requirement prior to beginning rehabilitative therapy at SIS.

Is there any reason not mentioned here why you should not follow a regular exercise or therapeutic rehabilitation program?

If yes, please explain:

_____

_____

_____

Additional comments you feel may be pertinent to the success of your therapy:

_____

_____

_____

I have completed this application to the best of my knowledge. I understand that if necessary, SIS reserves the right to request medical clearance before beginning any therapeutic exercise program and has the right to deny my participation in the program if requests are not met. I understand that participating in the program at SIS while under the influence of any substance or intoxicated (e.g. marijuana, alcohol, etc.) is strictly prohibited. I also understand that SIS reserves the right to discontinue and/or deny treatment to clients (to include family members, associates, etc.) who are rude, unruly or disruptive.

Client Name: _____

Signature: _____ Date: _____

If under 18, name of Parent/Guardian: _____ Relationship: _____

Signature: _____ Date: _____

Physical Therapy Prescription Form

StayInStep
SCI Recovery Center

Patient Name		DOB	
ICD-10 Diagnosis Code(s)		ICD-10 Accident Code(s)	
		Additional Code(s)	

Physician Name	
Follow Up Date	
Precautions	
Comments	

☐ Evaluate and Treat

☐ Other: (please specify)

☐ _____

I hereby certify that the prescribed Physical Therapy is medically necessary for this patient's plan of care.

_____ _____

Physician Signature Date

Physicians, please fax this referral slip to (813) 977-7444. THANK YOU!

WAIVER AND RELEASE FROM LIABILITY

I, _____, ("Client") hereby agree to release, indemnify, hold harmless and forever discharge ROMY AND GABY SCI FOUNDATION, INC. d/b/a STAY IN STEP FOUNDATION (the "Company") and its agents, employees, independent contractors, directors, affiliates, successors and assigns, of and from any all claims, demands, contracts, expenses, causes of action, lawsuits, damages, and liabilities of every kind of nature, whether known or unknown, in law or equity, that Client has had or may have, arising from or in any way related to Client's participation in any of the exercises, therapies, events, programs or activities conducted by or on the premises of or for the benefit of the Company. I represent that I am in satisfactory physical condition to participate in the Company's exercises, therapies, events, programs or activities. Client acknowledges that Company's exercises, therapies, events, programs or activities Client participates in will, in many cases, be an extreme test of Client's physical and mental limits and carry the potential for severe physical injury and even possibly death, yet Client agrees to assume all risks involved with participation on such exercises, therapies, events, programs or activities, and waives any liability of Company, waives any right to a lawsuit or claim against Company, and on behalf of Client's heirs, waives all such rights also. Client hereby assumes the risks of participating in all the Company's exercises, therapies, events, programs or activities. Client certifies that Client is physically and mentally able to participate in the Company's exercises, therapies, events, programs or activities and has not been advised otherwise by a qualified medical professional. Client understands that participating in the Company's exercises, therapies, events, programs or activities does not constitute medical treatment, diagnosis or advice. Client understands that Client should seek the advice of a physician or another qualified health provider, if Client has questions about medical condition(s) before beginning Company's exercises, therapies, events, programs or activities. Clients over the age of 60 years old understand that a bone density scan is required prior to participating in Company's programs, and that the bone density scans results will be shared with the Company. Client certifies that in consideration of becoming a client of the Company's programs, Client hereby takes the following action for itself, its executors, administrators, heirs, next of kin, successors and assigns: Client waives, releases and discharges Company from any and all claims or liability for any loss, damage, injury or death of any kind which arise out of or are related to Client's participation in Company's exercises, therapies, events, programs or activities or Client traveling to and from the Company's facilities; including but not limited to: 1) any known and unknown, foreseen and unforeseen body and personal injury, 2) loss of life, and 3) any attorney's fees, costs, expenses, or charges sustained, directly or indirectly, or alleged to have been sustained, or in any fashion, arising from, in connection with, or resulting from its participation in the Company's exercises, therapies, events, programs or activities, even if due to the negligence of the Company or any employee, independent contractor, volunteer, director, officer, client, owner or agent of Company. Client will indemnify and hold harmless the Company and any and all of Company's employees, independent contractor,

volunteers, directors, officers, clients, owners and agents thereof from any claim, demand, and/or cause of action of any nature whatsoever, related to the Client's participation in the Company's exercises, therapies, events, programs or activities, even if due to the negligence of the Company, including but not limited to any and all losses, liabilities, damages, costs and expenses (including reasonable attorney fees) arising out of such actions. Client agrees that Client, Client's family members, and any of Client's guests and invitees shall be bound by this agreement and the Company's policies, rules and guidelines. Client agrees that the Company's policies, rules and guidelines may be revised, supplemented, or amended in the sole and absolute discretion of the Company, and that any changes shall become immediately effective upon posting in the Company's facilities or on Company's website. Client further expressly agrees that the foregoing waiver and release from liability agreement is intended to be as broad and inclusive as permitted by the law of the State of Florida. Client has read this waiver and release from liability and indemnity clause, and agrees that no oral representations, statements or inducements apart from this agreement have been made. The Company makes no warranties or representation, express or implied, other than those set forth herein. IN NO EVENT SHALL THE COMPANY BE LIABLE FOR ANY SPECIAL, INCIDENTAL, ECONOMIC, NON-ECONOMIC, PUNITIVE OR CONSEQUENTIAL DAMAGES. This agreement shall be construed in accordance with the laws of the State of Florida, without regard to the conflicts of law provisions thereof. Any controversy, claim or dispute arising out of or relating to this agreement shall be settled by a single arbitrator, chosen by the Company, who shall formerly have been a judge in Hillsborough County, Florida. The parties agree to abide by all decisions and awards rendered in such arbitration proceedings and agree to waive any right to appellate review of said decision or award. Such decisions and awards rendered by the arbitrator shall be final and conclusive and may be entered in any court having jurisdiction thereof as a basis for judgment and of the issuance of execution for its collections. All such controversies, claims or disputes shall be settled in this manner in lieu of any action at law or equity, provided however, that nothing in this subsection shall be construed as precluding bringing an action for injunctive relief or other equitable relief. The arbitrator shall not have the right to award punitive damage or speculative damages to either party and shall not have the power to amend, alter, or reform this agreement in any manner. IF FOR ANY REASON THIS ABRITRATION CLAUSE BECOMES NOT APPLICABLE, THEN EACH PARTY, FULLY PERMITTED BY APPLICABLE LAW, HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY AS TO ANY ISSUE RELATING HERETO IN ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT OR ANY OTHER MATTER INVOLVING THE PARTEIS HERETO.

I authorize any person connected with Company to administer first aid to me, as they deem necessary. I authorize medical and surgical care and transportation to a medical facility or hospital for treatment necessary for my well-being, at my expense, if any person connected with Company deems this to be necessary, in their opinion.

I HAVE READ THE PREVIOUS PARAGRAPHS AND I KNOW, UNDERSTAND AND APPRECIATE THESE AND OTHER RISKS THAT ARE INHERENT IN THE COMPANY'S EXERCISES, THERAPIES, EVENTS, PROGRAMS OR ACTIVITIES. I HEREBY ASSERT THAT MY PARTICPATION IS VOLUNTARY AND THAT I KNOWINGLY ASSUME ALL SUCH RISKS AND ENTER THIS WAIVER AND RELEASE FROM LIABILITY VOLUNTARILY. I FURTHER UNDERSTAND AND AGREE THAT THIS AGREEMENT SHALL ALSO BE BINDING ON MY HEIRS, ASSIGNS, SUCCESSORS AND ALL OTHER PERSONS WHO MAY CLAIM THROUGH ME.

All notices to the Company shall be mailed (certified or registered, return receipt requested) to STAY IN STEP FOUNDATION, 10500 University Center Dr., Suite 130, Tampa, FL 33612. If any part of this agreement is held by a court of competent jurisdiction to be void and unenforceable, the remainder of the terms and provisions of this agreement shall remain in full force and effect and shall not be affected.

Client Name: _____

Client Signature: _____ Date: _____

Have you had a recent bone density assessment? Yes _____ No _____

If yes, please attach a recent bone density scan with the doctor's interpretation.

BONE DENSITY TESTING REQUIREMENTS

Our new clients over 60 years of age and/or 6 months post injury/re-injury must have a bone density test (Densitometry or DEXA scan) completed and have the results and doctor's interpretation sent or faxed to us. This result will show us if there is increased risk of fracture due to osteopenia or osteoporosis and determine program viability. It's important that you know this as well for your general health and well-being.

The test should include T scores of the Lumbar spine, Right and Left Hips, Greater Trochanter, and Distal Femur. If you have had a bone test performed in the last 6 months, you don't need to have another one done, but you still need to send or fax us the results. Follow-up requirements for subsequent testing will be determined by these initial test results.

We need to have this report prior to scheduling your initial evaluation appointment. Thank you.

Client Name: _____

Client Signature: _____ Date: _____

PAYMENT POLICIES

Supplemental Program (Self-Pay Clients Only)
Rate = $90 per hour for 2-hour session ($180)

OPTION 1

2-hour session/3 days a week (24 hours/month) = Total $2,160.00 initial payment ($1,080.00 + $1,080.00 refundable deposit) 50% discount kicks in at beginning of next month, **only if enrolled in auto-pay**.

OPTION 2

2-hour session/2 days a week (16 hours/month) = Total $1,440.00 initial payment ($936.00 + $504.00 refundable deposit) 35% discount kicks in at beginning of next month, **only if enrolled in auto-pay**.

OPTION 3

2-hour session/1 day a week (8 hours/month) = Total $720.00 initial payment ($540.00 + $180.00 refundable deposit) 25% discount kicks in at beginning of next month, **only if enrolled in auto-pay**.

OPTION 4

2-hour session/2 times a month (4 hours/month) =Total $360.00 initial payment ($306.00 + $54.00 refundable deposit) 15% discount kicks in at beginning of next month, **only if enrolled in auto-pay**.

LOCOMOTOR SATURDAYS

1-hour session of high-intensity ambulation = $75.00 total payment ($75.00 + $15.00 Supplemental Discount)

All Medicare/Medicaid/Private Insurance clients are required to pay initial 20% refundable deposit. The deposit will be used as a means by SIS to bridge any coverage gaps and collect unsecured payments. Self-Pay clients electing **NOT** to enroll in monthly auto-pay are required to pay initial 20% refundable deposit and will be subject to a maximum 20% monthly discount for the following months of treatment. All clients are responsible to pay for their chosen treatment option the month **PRIOR** to services being rendered.

We file insurance as a courtesy to our patients. Invoices are prepared and sent out on the last day of the month. All client payments are due by the 5th day of the month following treatment. Sessions and hours will be billed based on choice of treatment options. Every client will be required to provide valid bank account information and an active credit card, which will be used to enroll clients in monthly auto-pay and/or as a means of collection if payment is not made within 30 days of billing.

Management reserves the right to reduce, increase or cease the Supplemental discount at its discretion. Clients that miss or are late submitting payments are subject to a loss or permanently reduced Supplemental monthly discount rate.

Client Name: _____

Client Signature: _____ Date: _____

INSURANCE ASSIGNMENT/RELEASE

I, the undersigned, have insurance coverage and assign directly to the Stay in Step, Spinal Cord Injury Recovery Center (SIS), all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize SIS to release all information necessary to secure the payment of benefits. I authorize the use of SIS's assigned health care provider on all my insurance submissions. I am responsible for any fees that SIS, incurs for the full collections of payments.

Client Name: _____

Client Signature: _____ Date: _____

CREDIT CARD AGREEMENT

Between SIS and: _____
Print Name

NOTE: All credit card payments incur a 3% service charge for the total amount processed. All service charges/fees will be added to the principle payment and will be the responsibility of the client to cover.

Name on Card:	
Card Type:	
Card Number:	
Billing Address:	
Expiration Date:	
Security Code:	

Client Name: _____

Client Signature: _____ Date: _____

RECURRING PAYMENT AUTHORIZATION FORM

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize ROMY AND GABY SCI FOUNDATION, INC. d/b/a STAY IN STEP FOUNDATION to charge my credit card indicated below for $_____ on the _____ of each month for payment of my Rehabilitative Therapy.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify ROMY AND GABY SCI FOUNDATION, INC. d/b/a STAY IN STEP FOUNDATION in writing of any changes in my account information or termination of this authorization at least 30 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that ROMY AND GABY SCI FOUNDATION, INC. d/b/a STAY IN STEP FOUNDATION may at its discretion attempt to process the charge again within 30 days and agree to an additional $50 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

WORKERS' COMPENSATION COVERAGE

For those clients covered by Workman's Comp, SIS will send monthly invoices to the designated insurance company handling your individual case and will accept payment from the insurance company on your behalf.

The responsibility of payment for services rendered ultimately lies with the client. If, for whatever reason, the insurance company does not pay, the client accepts full responsibility for the outstanding balance and agrees pay the remaining balance in full within 10 days of initial notification to avoid reduction or loss of Supplemental Program discount.

If payment is not received within 15 days, the client will be removed from the schedule until full amount is received.

By signing this Agreement, the client acknowledges understanding of this policy and agrees to the outlined terms and provisions.

Client Signature: _____ Date: _____

CANCELLATIONS

Since our center is based on an appointment schedule, our policy is to charge for missed appointments, unless your appointment is cancelled within 24 hours in advance. Any session cancelled with less than a 24-hour notice; apart from medical emergencies (including weekends for Monday appointments), will be charged $50.00. Cancelations MUST be made to the office phone number (813-977-7999) or by email at diosa@stayinstep.org. In case of a true emergency, Patricia Diosa can be called on her cell phone at 813-966-2259.

Client Signature: _____ Date: _____

A. Patient Name: **B. SSN:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. PTT** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. PTT** below.

D. Physical Therapy Treatment (PTT)	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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