StayInStep
BRAIN AND SPINAL CORD INJURY RECOVERY CENTER

10500 University Center Drive Suite 130
Tampa, FL 33612
Phone: 813-977-7999 | Fax: 813-977-7444
Email: SIS@stayinstep.org

PHYSICAL THERAPY PRESCRIPTION FORM

Patient Last Name: _____First Name: _____Middle: ____

Nickname: _____DOB: _____

ICD10 – Diagnosis Code(s): _____ ICD10 – Accident Code(s): _____

Additional Codes: _____

Physician Name: _____ Follow up date: _____

Precautions: _____

Comments: _____

____ Evaluate and Treat

____ Other (Specify): _____

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

_____ _____
Physicians Signature Date

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

CLIENT APPLICATION FORM

The information obtained will remain confidential. It will be used solely by the staff of the Stay In Step Brain and SCI Recovery Center (SIS) in determining program eligibility.

Client Last Name: _____ First Name: _____ Middle: _____

DOB: _____ Gender ____M ____F Social Security Number: _____

Home Address: _____ Apt # _____

City, State, Zip: _____ Telephone Number: _____

Alternate Number: _____

May we leave a voicemail message on this number? ____ Yes ____ No

May we speak with someone who may answer this number? ____Yes ____ No

Email address: _____

May we communicate with you via email? ___ Yes ___ No

Employer Name: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship to client: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone: _____

Other Contact – Not living with client

Name: _____ Relationship to client: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Life Partner ___ Separated ___Widowed

Primary Language: _____ English _____Spanish _____ Other

How did you hear about us?

___ Billboard ___ Employer ___ Family member ___ Friend ___ Health Fair ___ Insurance

___ Magazine ___ News ___ Physician ___ Radio ___ Television ___ Website _____ Other

Medical Information:

Height: _____ Weight: _____ Date of Injury: _____

Cause of Injury: _____ Level of SCI: _____

Complete/Incomplete: _____ Current Rehab Program: _____

Physician Name: _____ Phone: _____

Describe your physical abilities

Upper extremity: _____

_____

_____

Trunk (IE: Can you sit up):_____

_____

_____

Lower extremity: _____

_____

_____

List any physical problems

____Yes ___ No Hypersensitivity

____Yes ___ No Osteoporosis/ Osteopenia

____Yes ___ No Pressure Sores/ Skin Breakdowns

____Yes ___ No Heterotrophic Ossification

____Yes ___ No Joint/ Muscle disorder

____Yes ___ No Knee instability

Briefly describe event(s) leading to the injury: _____

_____

_____

_____

Briefly explain unlisted symptoms: _____

_____

_____

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/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 a program at SIS.

Is there any reason not mentioned here why you should not follow a regular exercise or therapeutic rehabilitation program? _____Yes _____ No

If yes, please explain: _____

_____

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

_____

Number/Date of Last Hospitalization: _____

_____

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

_____

_____

_____

_____

_____

_____

_____

Special considerations: _____

_____

_____

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: _____

If under 18, name of parent or guardian: _____ Relationship: _____

Signature: _____ Date: _____

BONE DENSITY TESTING

BONE DENSITY TESTING REQUIREMENTS

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

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

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: _____

CLIENT CHAPERONE FORM

The information obtained in this application will remain confidential. It will be used solely by the staff of the Stay In Step Brain and SCI Recovery Center (SIS).

Patient Last Name: _____First Name: _____Middle: ____

Nickname: _____

DOB: _____ Social Security Number: _____ Gender ___M ___F

Home Address: _____ Apt # _____

City, State, Zip: _____ Telephone Number: _____

CHAPERONE NAME

Name: _____ Relationship to Patient: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone: _____

CHAPERONE NAME

Name: _____ Relationship to Patient: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone: _____

I understand that Stay In Step Brain and SCI Recovery Center (SIS) is a physical therapy facility and may not be able to administer medical or surgical care. Should an emergency arise, the client will be transported to a medical facility or hospital for treatment if any person connected with Company deems this to be necessary, in their opinion. Further, I understand that the Chaperone will be required to travel with the client.

Chaperone Signature: _____ Date: _____

Chaperone Signature: _____ Date: _____

MEDIA RELEASE FORM

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged.

I grant / do not grant to Stay In Step Brain and Spinal Cord Injury Recovery Center and to its employees, directors, officers, licensees, successors and assigns (each individually and collectively as "Stay in Step"), the irrevocable, royalty-free, perpetual, unlimited worldwide right to use, distribute, publish, exhibit, digitize, broadcast, display, modify and create derivative works of, reproduce or otherwise exploit my name, picture, likeness and voice (including any video footage of the same) (collectively "media"), for any purpose (except in a defamatory manner) including, without limitation, rights to use for educational, advertising, non-commercial or commercial purposes in any manner or media format whatsoever, and including, without limitation, publication of the media on the internet, radio, television and in printed form. I agree that I retain no interest in or ownership of any of the media.

I understand that I do not have any right to preview or approve or reject media use, I shall not be compensated for media use, and I waive any claim arising from media use (including, without limitation, waiver of any claim based upon invasion of privacy, libel or defamation) regardless of whether the media has been altered, blurred, or otherwise distorted. I agree that Stay in Step has no obligation to use the media. I hereby release and agree to hold harmless Stay in Step from any claim for injury, loss, damages or other liability which I may have, and which may arise from the use of any of the media.

Please Check One of the Following Options:

☐ I grant to Stay in Step my consent for media release

☐ I do not grant to Stay in Step my consent for media release

Name of Recipient/Legal Guardian (Print): _____

Signature of Recipient/Legal Guardian: _____

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 BRAIN AND SCI RECOVERY CENTER (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 ROMY AND GABY SCI FOUNDATION INC. D/B/A STAY IN STEP BRAIN AND SCI RECOVERY CENTER, 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: _____

FINANCIAL POLICY

Stay in Step believes that all patients deserve the best care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon.

Insurance

For those that want to use their insurance provider, our services are provided to you not your insurance company. Thus, payment for your treatment is ultimately your responsibility. We will bill your insurance regardless of our status as an out-of-network provider. As a courtesy to you, we will contact your insurance company and inform you of your policy's physical therapy benefits prior to your first visit. You are required to sign the agreement with the benefits quoted prior being seen for physical therapy. Please read the insurance benefits that your insurance company provided you to fully understand all waiting periods, frequency limitations, deductibles, and other exceptions/exclusions. If you change insurances, please inform us immediately. You are responsible for any deductible, co-pays, co-insurance and any services not covered by your plan. Co-pays are due at the time of service.

Self-Pay

We believe long term therapy is the only way to maintain a better quality of life, especially with these types of neurological disorders. We are aware that this type of non-traditional, long-term therapy, working one on one with 2 or more experienced people, is expensive. For these reasons, we decided to create a supplemental program to relive this financial burden.

** The Supplemental Program requires that payment be received in advance for services to be rendered**

ALL CLIENTS

We require a current prescription for physical therapy from your medical doctor. For Medicare clients, Medicare has a financial "No Cap" per calendar year for outpatient therapy. Certain neurological disorders must show improvement in order to qualify for this rule. Unfortunately, due to this condition, it can be very difficult for our clients to show this kind of improvement that insurance company's request. If this is the case, you will be responsible for all further payments during the calendar year.

If you are paying us through a 3rd party source, you will be charged the full amount for therapy services without the benefit of the supplemental program

Personal Liability Liability/Litigation

If you are working with an attorney for your claim, our financial policy is the same for everybody. Please let your attorney know that you are still responsible for payments.

SUPPLEMENTAL PROGRAM PAYMENT POLICIES

Supplemental Program (Self-Pay Clients Only) Rate = $90 per hour for 2-hour session ($180). Must enroll in auto-pay to qualify.

OPTION 1

2-hour therapy session/3 days a week (24 hours/month) = Total $2,160.00/month. Qualifies for 50% supplemental funds payment. Client pays $1080.00/month and receives $1080.00/month supplemental funds.

OPTION 2

2-hour therapy session/2 days a week (16 hours/month) = Total $1,440.00/month. Qualifies for 35% supplemental funds payment. Client pays $936.00/month and receives $504.00/month supplemental funds.

OPTION 3

2-hour therapy session/1 day a week (8 hours/month) = Total $720.00/month. Qualifies for 25% supplemental funds payment. Client pays $540.00/month and receives $180.00/month supplemental funds.

OPTION 4

2-hour therapy session/2 times a month (4 hours/month) =Total $360.00/month. Qualifies for 15% supplemental funds payment. Client pays $306.00/month and receives $54.00/month supplemental funds.

All clients are responsible to pay for their chosen treatment option the month **PRIOR** to services being rendered.

Management reserves the right to reduce, increase or cease the Supplemental discount at its discretion. As an in-house courtesy, we allow clients to roll over/reschedule appointments based on scheduling availability. This courtesy is available only to clients that cancel/reschedule **EARLIER THAN** 24 hours prior to their assigned appointment time, regardless of reason for appointment cancellation. Clients that miss or are late submitting payments are subject to a loss or permanently reduced Supplemental monthly discount rate.

I understand that I am responsible for all copays, deductibles, coinsurance and amounts not covered by insurance. I assign to SIS all insurance payments made for any services provided to me and direct SIS to represent me in any grievances or appeals process related to the payment of services rendered by SIS.

Client Name: _____

Client Signature: _____Date: _____

NOTICE OF PRIVACE PRACTICES ACKNOWLEDGEMENT

____ I acknowledge that I have received a copy of the Notice of Privacy Practices.

____ I acknowledge that I have refused to accept a copy of the Notice of Privacy Practices.

Print Name:_____ Date:_____

Signature:_____

CLIENT COPY KEEP FOR YOUR RECORDS

NOTICE OF PRIVACY PRACTICES
For PROTECTED HEALTH INFORMATION (HIPAA)

Stay In Step
10500 University Center Drive, Suite 130
Tampa, Florida 33612

Effective Date: August 12, 2019

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

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing-related information. This information is considered Protected Health Information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities
Our Organization is required to maintain the privacy of your health information and to provide you with a description of our legal duties and Privacy Practices regarding your health information that we collect and maintain.
We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain. Copies of our Notice are available in our main reception area(s) and on our website.

How We May Use and Disclose Your Medical Information
Our practice may use a patient sign-in sheet that is visible to other patients; this is acceptable under the Privacy Rule.

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care.

We may communicate your information using various methods, orally, written, facsimile, and electronic communications. We may contact you to remind you of your appointment by telephone, reminder card, or email unless requested otherwise. Our office contains open areas whereas conversations may be overheard, we will make every attempt to minimize the exposure of your PHI and if requested; we will relocate to a private room.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. Examples may include contacting your insurance company for referrals, verification, or pre-approval of covered services.
For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support, and conducting or arranging for other business activities such as lab or radiology interfaces within the EHR, and through a Health Information Exchange (HIE) program. We may use or disclose, as needed, your health information within a medical group to support your care.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/treatment plan and diagnosis.

Business Associates, BA: Provide services for our organization through written contracts and/or service agreements. Examples of these services include billing, collection, and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third-party payer for services rendered. The BA is also required by law to protect and safeguard your health information which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification: In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within 60 days of the breach unless our state law is more stringent, then we will abide by our state law. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made *With* Your Consent, Authorization or Opportunity to Object: We will not use or disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for most uses and disclosures for medical research, the use of psychotherapy notes, and certain disclosures of sensitive health information. This may include the performance or results from a test or treatment of HIV, HIV related conditions, or drug/alcohol programs and treatment. If our practice participates in medical research and all patient identifiers have been removed we are not required under the Privacy Rule to obtain an authorization from you. If you do provide an authorization to use or disclose medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to retrieve any disclosures we have already made with your authorization.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our Privacy Officer.
Fundraising initiatives; if applicable are limited and may require a separate authorization.

Uses and Disclosures That May Be Made *Without* Your Authorization or Opportunity to Object: We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation or a communication barrier), then your healthcare provider may, using professional judgment will determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have reporting requirements which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

Your Health Information Rights
Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representative have the right to inspect, review and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient

portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or a review must be submitted in writing to our practice. There will be a fee charged for all applicable copying and producing a copy of portable media up to the maximum amount as prescribed by governing law.

Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.
We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment, health care operations, or disclosures authorized by you. This request must be in writing and a time period, but may not be longer than six (6) years or before April 14, 2003. Our Practice will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or health care operations.
Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

Other Restrictions, Limiting Information: You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.
We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or address. We ask that you submit these requests in writing.

For More Information or to Report a Problem
If you have questions or want to exercise any of your rights, please submit your request in writing to the practice's privacy officer indicated below.
If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred and there will be no retaliation for filing a complaint.

Privacy Officer: **Gaby Camargo**
10500 University Dr. Suite 130, Tampa, FL 33612
813.977.7999 Phone | 813.977.7444 Fax

No Show / Cancellation Policy

Stay In Step Brain and Spinal Cord Injury Recovery Center strives to provide each client with the highest quality of care while attempting to accommodate your schedule for your convenience. We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other client's scheduling needs and keeps the clinic operating at is most efficient level. Due to our two hour treatment sessions, missed appointments are a significant inconvenience to the clinic, other clients and your recovery.

We ask for your full cooperation with the following policy:

- If you are more than 30 minutes late for your appointment and fail to notify us, treatment may becancelled and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a fee will becharged for that appointment.
- No Shows - Failure to show up for an appointment without notifying us will result in a fee being charged for that appointment. Two consecutive no shows will result in the cancellation of all remaining scheduled appointments.
- Clients will be charged a $50 cancellation fee for each late, late cancelled, or no show appointment. The client is responsible for the fee, not the insurance/third party payor.
- No cancellation fee will be charged for rescheduled appointments.
- All cancellations and no shows will be documented in your medical record and appropriately reported toyour physician and insurance/third party payor.
- Repeated failure to comply with this Cancellation Policy will result in being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

To Cancel: Please call the office (813-977-7999) or email (SIS@stayinstep.org) at least 24 hours in advance (Monday appointments need to be cancelled by Friday, unless due to illness). DO NOT email or text your therapist/trainer to change or cancel an appointment.

All of the staff at ***Stay In Step*** appreciates your anticipated adherence and cooperation with this policy. We are here to help you attain all of your goals.

Please sign and return this copy to Stay In Step.

I have read and understand the above No Show / Cancellation Policy.

_____ ____ /_____/ ____

Client Acknowledgement/Signature Date

No Show / Cancellation Policy

Stay In Step Brain and Spinal Cord Injury Recovery Center strives to provide each client with the highest quality of care while attempting to accommodate your schedule for your convenience. We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other client's scheduling needs and keeps the clinic operating at is most efficient level. Due to our two hour treatment sessions, missed appointments are a significant inconvenience to the clinic, other clients and your recovery.

We ask for your full cooperation with the following policy:

- If you are more than 30 minutes late for your appointment and fail to notify us, treatment may becancelled and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a fee will becharged for that appointment.
- No Shows - Failure to show up for an appointment without notifying us will result in a fee being charged for that appointment. Two consecutive no shows will result in the cancellation of all remaining scheduled appointments.
- Clients will be charged a $50 cancellation fee for each late, late cancelled, or no show appointment. The client is responsible for the fee, not the insurance/third party payor.
- No cancellation fee will be charged for rescheduled appointments.
- All cancellations and no shows will be documented in your medical record and appropriately reported toyour physician and insurance/third party payor.
- Repeated failure to comply with this Cancellation Policy will result in being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

To Cancel: Please call the office (813-977-7999) or email (SIS@stayinstep.org) at least 24 hours in advance (Monday appointments need to be cancelled by Friday, unless due to illness). DO NOT email or text your therapist/trainer to change or cancel an appointment.

All of the staff at ***Stay In Step*** appreciates your anticipated adherence and cooperation with this policy. We are here to help you attain all of your goals.

Please keep this copy for your records.