www.stayinstep.org
13085 Telecom Pkwy N
Temple Terrace, FL 33637
Phone: 813.977.7999
Fax: 813.977.7444

Client Application Checklist

_____Copy of Insurance Card

_____Copy of ID

_____Application Form

_____Physical Therapy Prescription Form

_____Client Chaperone/Driver information

_____No-Show/Cancelation Policy

_____Client Financial Policy

_____Notice of Privacy Practices

_____HIPAA Acknowledgement

_____Waiver of Liability

_____Media Release

_____Recurring Payment Authorization

_____Bone Density Testing

_____Eligibility & Benefits Review

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CLIENT APPLICATION

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

Client Last Name: _____ **First Name:** _____ **Middle Initial:**_____

DOB: _____ **Gender:** ____M ____F **Social Security Number:** _____

Home Address: _____ **Apt #:** _____

City, State, Zip: _____ **Phone #:** _____

Alternate number: _____

May we leave a voicemail 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:** _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Life Partner ____ Separated ____Widowed

Primary Language: _____ English _____Spanish _____ Other

Emergency Contact

Name: _____ **Relationship to Client:** _____

Address: _____ **Apt #:** _____

City, State, Zip: _____ **Phone #:** _____

Power of Attorney or Patient's Representative

Name: _____ **Relationship to client:** _____

Address: _____ **Apt #:** _____

City, State, Zip: _____ **Phone #:** _____

Medical Information

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

_____

_____

_____

_____

_____

Briefly explain unlisted symptoms: _____

_____

_____

_____

_____

_____

Height: _____ **Weight:** _____ **Date of Injury:** _____ **Level of SCI:** _____

Complete/Incomplete: _____

Is the patient currently participating in another physical therapy program or home health? _____

Physician Name: _____ **Phone #:** _____

Describe your Physical Abilities

Upper Extremity: _____

_____

_____

Trunk (I.E., Can you sit up):

_____

_____

_____

Lower Extremity: _____

_____

_____

Medical History

History	Yes	No	Explanation/Frequency
Alcohol			
Tobacco			
Diabetes			
Chest Pain			
Hypertension/Hypotension			
Obesity			
Muscle Tension			
Breathing/Lung Problems			
Heart Disease			
Ventilator Dependent			
Tendon/Joint Problems			
Hypersensitivity			
Osteoporosis/Osteopenia			
Pressure Sores/Skin Breakdown			
Heterotrophic Ossification			
Other			

Are you aware of anything that will complicate your participation in an intense exercise program? ____

_____

Are you involved in any recreational physical activities? _____

_____

Has your physician-approved your participation in an intense exercise? _____

Date of Last Hospitalization & Number of Hospitalizations: _____

_____

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

_____

_____

_____

_____

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 intoxication (e.g., marijuana, alcohol, etc.) is strictly prohibited. I also understand that SIS reserves the right to discontinue and/or deny treatment to clients (including family members, associates, etc.) who are rude, unruly, or disruptive.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Signature of patient or patient's representative/parent Date

_____

Relationship to patient

How did you hear about us?

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

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

StayInStep
BRAIN AND SPINAL CORD INJURY RECOVERY CENTER

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Fax: 813.977.7444

PHYSICAL THERAPY PRESCRIPTION FORM

Patient Last Name: _____First Name: _____ Middle Initial: _____

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

_____ _____
Physician Signature Date

Physician, please fax this referral slip to (813) 977-7444. Thank you!

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Fax: 813.977.7444

CLIENT CHAPERONE/TRANSPORTATION FORM

Clients Who Do Not Drive Must Complete

Patient Last Name: _____First Name: _____Middle Inital: ____

Nickname: _____

DOB: _____ Gender: ___M ___F

Home Address: _____ Apt # _____

City, State, Zip: _____ Phone Number: _____

CHAPERONE/TRANSPORTATION NAME 1

Name: _____ Relationship to Patient: _____

Address: _____ Apt #: _____

City, State, Zip: _____ Phone: _____

CHAPERONE/TRANSPORTATION NAME 2

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 necessary, in their opinion. Further, I understand that the Chaperone will be required to travel with the client. ***A chaperone MUST accompany patients who are unable to communicate for themselves.***

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature of patient or patient's representative/parent Date

_____
Relationship to patient

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NO-SHOW/LATE CANCELLATION POLICY

Stay In Step strives to provide each client with the highest quality care. No-shows, late cancellations, and late arrivals cause problems that go beyond a financial impact on our organization. When an appointment is made, it takes an available time slot away from another client.

A "no-show" is missing a scheduled appointment. A "late cancellation" is canceling an appointment without calling or emailing the office to cancel within **24 hours** of an appointment. A "late arrival" is arriving 30 minutes late to an appointment.

We understand that situations such as medical emergencies occasionally arise, and these situations will be considered on a case-by-case basis.

Two consecutive no-shows will result in the cancellation of all remaining scheduled appointments.

- Clients will be charged a **$50 cancellation fee** for each no-show, late cancellation, or late arrival. The client is responsible for the fee, not the insurance/third-party payor. Payment will be due at the following appointment.

All no-shows, late cancellations, and late appointment arrivals will be documented on a client's medical record and appropriately reported to physicians and insurance/third-party payors.

- Repeated failure to comply with this Cancellation Policy will result in being placed on a "Schedule Based on Availability" list. This will require clients to call for an open appointment.

Please understand that insurance companies consider this charge entirely the patient's responsibility.

To cancel or reschedule an appointment, please call Stay In Step at 813-977-7999 or email sis@stayinstep.org. **(Monday appointments** need to be canceled by Friday unless due to illness). This policy is in effect to ensure that all our clients can be seen in a timely manner.

I HAVE READ AND UNDERSTAND THE ABOVE NO-SHOW/LATE CANCELLATION POLICY.

Please sign and return this copy to Stay In Step.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature of patient or patient's representative/parent Date

_____
Relationship to patient

NO SHOW/LATE CANCELLATION POLICY

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KEEP THIS COPY FOR YOUR RECORDS

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CLIENT FINANCIAL POLICY

Thank you for choosing Stay In Step as your long-term rehabilitative care provider. We are committed to providing you with quality, compassionate care, and we appreciate your commitment to adhering to this financial policy. Please ask if you have any questions about our fees, policies, or your responsibilities. It is your responsibility to notify our office if any patient information changes (i.e., name, address, telephone number, insurance information, etc.)

Insurance

We participate with a few insurance companies, including Medicare. However, we will accept clients that are out of network. As a courtesy to you, we will contact your insurance company and inform you of your policy's physical therapy benefits before your first visit. You are required to sign the agreement with the benefits quoted before 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.

- 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.
- For Medicare clients, Medicare has a financial "No Cap" per calendar year for outpatient therapy. Certain neurological disorders must show improvement to qualify for this rule. Unfortunately, due to this condition, it can be challenging for our clients to show the kind of improvement that the insurance company requests. If this is the case, you will be responsible for all further payments during the calendar year.

Proof of Insurance

All clients must complete our client application form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to promptly provide us with the correct insurance information, you may be responsible for the balance of a claim.

Co-Payments & Deductibles

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. To make payments convenient, we accept Visa, master card, American Express, cash, and checks. The charge for a returned check is $35, payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount. You may be placed on a cash-only basis following any returned check.

Non-covered Services

Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

Claims submission

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Self-Pay

Self-pay accounts are clients without insurance coverage, clients covered by insurance plans in which the organization does not participate, or clients without an insurance card on file with us.

Supplemental Program

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 relieve this financial burden.

- Invoices will be sent at the beginning of the next month for the previous month of services
- A credit card must be on file to process the payment on the 5th of every month

ALL CLIENTS

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.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY

_____ _____

Patient Name Patient Date of Birth

_____ _____

Signature of patient or patient's representative/parent Date

_____

Relationship to patient

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NOTICE OF PRIVACY PRACTICES

CLIENT COPY KEEP FOR YOUR RECORDS

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 get in touch with 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 about your medical information and applies to all 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, text message, reminder card, or email unless requested otherwise. Our office contains open areas where 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 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 B.A. so they can perform the services we have asked them to do, such as billing your third-party payer for services rendered. The B.A. 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: If there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a B.A., 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 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 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, congenital disability 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 the 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 for 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 healthcare 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 for 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. Suppose you believe that your (or someone else's) privacy rights may have been violated. In that case, 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**
13085 Telecom Pkwy N, Temple Terrace, FL 33637
813.977.7999 Phone | 813.977.7444 Fax

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Temple Terrace, FL 33637
Phone: 813.977.7999
Fax: 813.977.7444

HIPAA ACKNOWLEDGMENT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Date of Birth: _____

We at Stay In Step are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our Office Manager in person or by Phone on our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative/parent Date

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Relationship to patient

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Fax: 813.977.7444

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. The Client's participation will, in many cases, be an extreme test of the Client's physical and mental limits and carry the potential for severe physical injury and possibly death. Yet, Client agrees to assume all risks involved with participation in 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.

The 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 understand that a bone density scan is required before participating in the Company's programs and that the bone density scan 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 contractors, 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. The Client further expressly agrees that the foregoing waiver and release from liability agreement are intended to be as broad and inclusive as permitted by the law of the State of Florida. The 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 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. They 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 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 the 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 the treatment necessary for my well-being, at my expense, if any person connected with the Company deems this 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 PARTICIPATION 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, 13085 Telecom Pkwy N Temple Terrace, FL 33637. Suppose any part of this agreement is held by a court of competent jurisdiction to be void and unenforceable. In that case, the remainder of the terms and provisions of this agreement shall remain in full force and effect and shall not be affected.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Signature of patient or patient's representative/parent Date

_____

Relationship to patient

www.stayinstep.org
13085 Telecom Pkwy N
Temple Terrace, FL 33637
Phone: 813.977.7999
Fax: 813.977.7444

Media Release

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

I _____ authorize 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 authorize Stay in Step and give my consent for media release

_____I do not give Stay In Step authorization to use my image

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature of patient or patient's representative/parent Date

_____
Relationship to patient

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RECURRING PAYMENT AUTHORIZATION FORM

Self-pay clients and clients needing to have a payment method on file will be required to complete this form. Recurring payments will be charged on the 5th of each month, and clients will be provided with an invoice before charges are made to a credit card or checking/savings account. A receipt for each payment can be emailed or printed for your convenience. In the event, payment cannot be debited from a credit card or checking/savings account, you will be notified and will have five (5) business days to render payment. Until payment is received, all appointments will be placed on hold. If payment is made through a trust, please provide the information to send invoices.

Please complete the information below:

I _____ authorize Romy and Gaby SCI Foundation INC. DBA Stay In Step Brian and Spinal Cord Injury Recovery Center to charge my credit card below on the _____ of each month for payment of my rehabilitative therapy.

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Checking/Savings Account

Name on Acct_____

Bank Name _____

Acct # _____

Routing # _____

Bank City & State _____

Credit Card

Visa MasterCard Amex Discover

Cardholder Name _____

Card # _____

Exp. Date _____

Security Code _____

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature of patient or patient's representative/parent Date

_____
Relationship to patient

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Stay In Step Brain and Spinal Cord Injury Recovery Center 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 date falls on a weekend or holiday, I understand that the payment 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 Stay In Step Brain and Spinal Cord Injury Recovery Center 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 organization 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.

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BONE DENSITY TESTING

BONE DENSITY TESTING REQUIREMENTS

Only for Clients 60 Years and Older

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 six (6) months post-injury/re-injury must complete a bone density test (Densitometry or DEXA scan) and have the results and doctor's interpretation sent or faxed to us. This result will show us if there is an increased risk of fracture due to osteopenia or osteoporosis and determine program viability. You must 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 six (6) months, you don't need to have another one done, but you still need to send or fax us the results. These initial test results will determine follow-up requirements for subsequent testing.

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

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Fax: 813.977.7444

INSURANCE ELIGIBILITY & BENEFITS

EMPLOYEES ONLY

DATE OF VERIFICATION_____

PATIENT NAME (ON INSURANCE CARD) _____ D.O.B._____

ADDRESS_____

EMAIL_____ REFERRED BY (PHYSICIAN)_____

PATIENT PHONE #_____ _____

PRIMARY INSURANCE_____

POLICY ID#_____ GROUP_____

POLICY EFFECTIVE DATE_____TO_____ IN NETWORK _____ OUT OF NETWORK_____

PATIENT HAVE OUT-OF-NETWORK BENEFITS? _____(Y/N), PLANT TYPE; HMO PPO POS OTHER___

INDIVIDUAL _____ FAMILY_____ DED_____AMOUNT OF DED. MET: _____

CO-INS._____ COPAY_____ OUT OF NETWORK FINANCIAL RESPONSIBILITIES $_____

INSURANCE RESPONSIBILITIES $_____ OUT OF POCKET; _____ VISITS LIMITS? _____

IS AUTHORIZATION FOR PT REQUIED____(Y/N). IS AUTHORIZATION FOR PT EVAL. REQUIRED? ___(Y/N)

INSURANCE PHONE # ON CARD_____

REF #_____ NAME _____

NAME OF EMPLOYEE_____

SECONDARY INSURANCE_____

POLICY ID#_____ GROUP_____

POLICY EFFECTIVE DATE_____TO_____ IN NETWORK _____ OUT OF NETWORK_____

PATIENT HAVE OUT-OF-NETWORK BENEFITS? _____(Y/N), PLANT TYPE; HMO PPO POS OTHER___

IS AUTHORIZATION FOR PT REQUIED____(Y/N). IS AUTHORIZATION FOR PT EVAL. REQUIRED? ___(Y/N)

INSURANCE PHONE # ON CARD_____

REF #_____ NAME _____

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Phone: 813.977.7999
Fax: 813.977.7444

NAME OF EMPLOYEE_____

DATE _____ HOUR_____ THE PATIENT WAS ORIENTED ABOUT THEIR ELIGIBILITY, BENEFITS, AND RESPONSIBILITIES.

PATIENT OR CUSTODIAN SIGNATURE_____

EMPLOYEE_____