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

CLIENT APPLICATION FORM

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 (IE: 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 Hospilatizations: _______________________

____

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, Stay In Step reserves the right to request medical clearance before beginning any therapeutic exercise program and can deny my participation 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 Stay In Step reserves the right to discontinue and/or deny treatment to clients (including family members, associates, etc.) who are rude, unruly, or disruptive.

____ ___________________

Client Name Client Date of Birth

____ ___________________

Signature of Client or Client's representative/parent Date

____

Relationship to Client

How did you hear about us?

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

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

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!

CLIENT CHAPERONE/CAREGIVER & TRANSPORTATION FORM

Stay In Step requires any client who cannot drive themselves to be accompanied by a chaperone or caregiver.

Client Last Name: __________________**First Name:** ____________________**Middle Inital:** ____

DOB: _________ **Gender:** ___M ___F

Home Address: ____ **Apt #** ____________

City, State, Zip: _______________________________________ **Phone Number:** ______________

CHAPERONE/CAREGIVER OR TRANSPORTATION NAME 1

Name: _______________________________ **Relationship to Client:** ________________

Address: ____ **Apt #:** _____________

City, State, Zip: ____ **Phone:** _____________

CHAPERONE/CAREGIVER OR TRANSPORTATION NAME 2

Name: _______________________________ **Relationship to Client:** ________________

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 the Company deems this necessary, in their opinion. Further, I understand that the Chaperone must travel with the client.

____ ___________________
Client Name Client Date of Birth

____ ___________________
Signature of client or client's representative/parent Date

____
Relationship to client

NO-SHOW/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 the 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 without notifying the office. A late cancellation is canceling an appointment without calling or emailing the office to cancel within **24 hours** of an appointment.

We understand that situations such as medical emergencies occasionally arise, and we will consider each case individually.

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 and late cancellation. The client is responsible for the fee, not the insurance/third-party payor. Payment will be due at the following appointment.

All no-shows and late cancellations 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** must be canceled by Friday unless due to illness.) This policy ensures 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.

____ __________________

Client Name | Client Date of Birth

____ __________________

Signature of Client or Client's representative/parent | Date

____

Relationship to Client

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 let us know if you have any questions about our fees, policies, or 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 two 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

____ ___________________
Client Name Client Date of Birth

____ ___________________
Signature of Client or client's representative/parent Date

____
Relationship to client

NOTICE OF PRIVACY PRACTICES

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.

Our Pledge and Responsibilities: Stay In Step is committed to protecting the privacy of medical information we create or obtain about you. This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to (i) make sure your medical information is protected, (ii) give you this Notice describing our legal duties and privacy practices with respect to your medical information, and (iii) follow the terms of the Notice that is currently in effect. 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.

Who Will Follow This Notice: All healthcare professionals, employees, medical staff, trainees, students, and volunteers of the Stay In Step organization will follow the privacy practices described in this Notice.

How We May Use and Disclose Your Medical Information: The following sections describe different ways we may use and disclose your medical information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure will be listed. All of the ways we are permitted

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. As needed, we may use or disclose 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.

Fundraising Activities: We may contact you to provide information about Stay In Step-sponsored activities, including fundraising programs and events to support research, education, or client care at Stay In Step. For this purpose, we may use your contact information, such as your name, address, phone number, the dates you received treatment at Stay In Step, your treatment outcome, and your health insurance status. The communication you receive will have instructions on how you may ask for us not to contact you again for such purposes, also known as an "opt-out."

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 by our Business Associate Agreement and written contracts/service agreements.

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 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 cannot retrieve any disclosures we have already made with your authorization.

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 Office.

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 (permission) 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:

- To tell you about or recommend possible treatment alternatives
- To inform you of benefits or services we may provide
- In the event of a disaster, to organizations assisting in a disaster relief effort so that your family can be notified of your condition and location
- As required by state and federal law

- To prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person
- To authorize federal officials for intelligence, counterintelligence, or other national security activities
- To coroners, medical examiners, and funeral directors, as authorized or required by law as necessary for them to carry out their duties
- To the military, if you are a member of the armed forces and we are authorized or required to do so by law
- For workers' compensation or similar programs providing benefits for work-related injuries or illnesses
- To authorize federal officials so they may conduct special investigations or provide protection to the U.S. President or other authorized persons
- If you are a potential organ donor, to organizations that handle such organ procurement or transplantation or to an organ bank, as necessary to help with organ procurement, transplantation, or donation
- To governmental, licensing, auditing, and accrediting agencies
- To a correctional institution as authorized or required by law if you are an inmate or under the custody of law enforcement officials
- To third parties referred to as "business associates" that provide services on our behalf, such as billing, software maintenance, and legal services
- Unless you say no to anyone involved in your care or payment for your care, such as a friend, family member, or any individual you identify
- For public health purposes
- To courts and attorneys when we get a court order, subpoena, or other lawful instructions from those courts or public bodies or to defend ourselves against a lawsuit brought against us
- To law enforcement officials as authorized or required by law

Your Health Information Rights: The records of your medical information are the property of Stay In Step. You have the following rights, however, regarding medical information we maintain about you:

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. Our Practice will provide you with the first accounting 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.

<u>Request Restrictions</u>: 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. You must pay for services in full and 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.

<u>Request Confidential Communications</u>: 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.

<u>Breach Notification:</u> If 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.

Personal Representatives, Minors, and Guardians: If you have given someone the legal authority to exercise your rights and choices about your health information, we will honor such requests once we verify their authority. This Notice also applies to minors and some disabled adults. They enjoy the same privacy protections for their medical information. However, because they usually cannot make health care decisions for themselves, a parent or a guardian can make decisions on their behalf. Parents or guardians can permit the use and release of this medical information. Parents or guardians may also hold all rights listed in this Notice including the right to inspect and copy and the right to amend.

<u>For More Information or to Report a Problem:</u> If you have questions or want to exercise any of your rights, please submit your request in writing to the Practice's privacy office 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 Office
13085 Telecom Pkwy N, Temple Terrace, FL 33637
813.977.7999 Phone | 813.977.7444 Fax

ACKNOWLEDGMENT OF RECEIPT

Notice of Privacy Practices

Printed Client Name: ____________________________________

Client Date of Birth: ______________________

At Stay In Step, we 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.

I acknowledge that I have reviewed the Notice of Privacy Practices.

____ ________________
Signature of client or client's representative/parent Date

____
Printed name of client or client's representative/parent

____
Relationship to client

HIPAA Medical Release Form

Please complete all sections of this HIPAA release form.

Section I.

I, ____, give permission for Stay In Step Brain and Spinal Cord Injury Recovery Center to share the information listed in Section II of this document with the person (s) or organization (s) I have specified in Section IV of this document.

Section II. Health Information

I want to give the below healthcare organization permission to:
Check the appropriate:

☐ Disclose my complete health information, including, but not limited to, diagnoses, lab test results, chart notes, treatment, and billing records for all conditions.

OR

☐ Disclose my complete health record except for the following information.

☐Mental Health Records
☐Genetic Information
☐Other (specify)
____

Form of disclosure:

☐Verbal
☐Electronic copy or access via web portal
☐Hard copy

Section IV. Who can Receive My Health Information

I authorize my health information in Section II to be shared with the following individual (s) or organization (s).

Name: ____

Organization: ____

Address: ____

Phone Number: ____

Name: ____

Organization: ____

Address: ____

Phone Number: ____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing the privacy and security of data and may be permitted to share further the information provided to them.

Section V. Duration of Authorization

This authorization will expire on _____________, unless otherwise revoked. If this date is left blank, this authorization will automatically expire if a patient has not been seen within two years from the date below.

I understand that I am permitted to revoke this authorization to share my health information at any time and can do so by submitting a request in writing to:

Attn: Office Manager
sis@stayinstep.org

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI. Signature

Client Name: _______________________________________ Date: ___________________

Client Signature: ____

If this form is being completed by a person with legal authority to act on the client's behalf, such as a parent, guardian, or caretaker, please complete the following information.

Name of person completing this form: ____

Signature of the person completing this form: ____

Describe the relationship between yourself and the client: _____________________________________

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 the 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 participating 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. 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. The client will indemnify and hold harmless the Company and any 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 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 the 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 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.

____ __________________

Client Name Client Date of Birth

____ __________________

Signature of client or client's representative/parent Date

____

Relationship to client

Photo/Video/Audio Consent & Release Form

This Form is Intended to Acknowledge/Confirm Your Understanding. Your Signature Below Indicates Your Approval and Agreement with its Contents.

☐I, the undersigned, agree and authorize Stay In Step Brain and Spinal Cord Injury Recovery Center to conduct photography, video recordings, or audio recordings for any/all of the following purposes.

☐Publicity and advertising material, including printed publications and newsletters
☐Presentations, conference, and exhibition materials
☐Websites, social media channels, and digital media communications
☐News media and their associated websites and their social media channels
☐Partnering organizations and their associated websites and social media channels
☐For advertising purposes, including in connection with my care and treatment
☐For online testimonials and reviews
☐For educational purposes in connection with medical research and community education
☐Other purposes (please specify) ____

I agree that such interviews, recordings, articles, quotes, photographs, films, audio or video, and/or any reproductions of same in any form, will become the property of Stay In Step Brain and Spinal Cord Injury Recovery Center. I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me.

I hereby release Stay In Step Brain and Spinal Cord Injury Recovery Center, its affiliates, employees, representatives, and agents from any and all claims, demands, costs, and liability that may arise from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed.

I hereby waive all rights and release Stay In Step Brain and Spinal Cord Injury Recovery Center, Inc. from any claim and/or cause of action, whether now known or unknown, for defamation or invasion of the right to privacy, publicity, or personality or any similar matter, or based upon or relating to the use and exploitation of my name, image, and likeness in connection with the aforementioned purposes.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

I understand I may revoke this authorization at any time by sending a request in writing to sis@stayinstep.org Attn: Office Manager. I understand that the revocation will not apply to any release of information or actions that had previously taken place before the revocation. **I further acknowledge that information shared on specific internet/social media platforms, although removed, may remain indefinitely.**

By signing below, I know that my protected health information will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form, it will continue to be used. I understand that information about me used or disclosed under this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting the privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

____ _____________________
Client Name Client Date of Birth

____ _____________________
Signature of client or client's representative/parent Date

____
Relationship to client

RECURRING PAYMENT AUTHORIZATION FORM

Self-pay clients and clients needing 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 upon request. A receipt for each payment can be emailed or printed for your convenience. If 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 5th of each month for payment of my rehabilitative therapy.

Billing Address ___________________________________

City, State, Zip ____________________________________

Phone # ___________________

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 ________________________

____
Client Name

____
Client Date of Birth

____
Signature of Client or Client's representative/parent

____
Date

____
Relationship to Client

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.

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.

Initial Client Survey

Please complete the following survey. After 6 months, we will conduct a follow-up survey to monitor progress.

https://forms.office.com/r/bFiQnTjXD0