Gina Rooney PT, LMT
800 N. Swan, Ste. #112
Tucson, AZ 85711
520.870.5794
gina@setyourfasciafree.com
www.setyourfasciafree.com

Client Intake Form

Name:_____DOB:_____Age:_____

Address:_____

_____

Telephone:_____

E-mail: _____

Occupation/Employer:_____

Primary Care Provider (PCP): _____

PCP's phone #: _____

Referred by: _____

Emergency Contact:_____Relationship: _____

Emergency Contact Phone #:_____

Reason for seeking MFR/Primary Medical Concern:

_____

_____

_____

Goals for MFR Therapy:

_____

_____

Past Medical History:

_____

_____

_____

Past Surgical History (including oral surgery):

_____

_____

_____

Current Medications &/or Supplements:

_____

_____

Allergies and reactions:

_____

_____

Client signature: _____ Date: _____

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Consent to Treat

I _____ agree and consent to a licensed physical therapist at Set Your Fascia Free, LLC to perform a physical therapy evaluation and/or rehabilitative treatment and care which include but are not limited to manual therapy, tissue or joint mobilization, myofascial release, therapeutic exercise and activities, postural reeducation, balance reeducation, gait reeducation, and/or neuromuscular reeducation and general massage therapy.

I understand and am informed that, as in the practice of medicine, physical therapy and massage therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment. I authorize a licensed physical therapist at Set Your Fascia Free, LLC to perform any additional or different treatment, which is deemed necessary should, during treatment, a condition be discovered which was not previously known.

I have carefully read and fully understand this informed consent form and have had the opportunity to discuss my condition with a licensed physical therapist at Set Your Fascia Free, LLC.

_____
Signature of patient Date

_____Relationship to patient:_____Date:_____
Signature of representative/parent/guardian who is authorized to sign for medical treatment of minor patient

Cancellation/No Show/Tardy Policy

Your treatment time has been scheduled specifically for you. Canceling or not showing up affects not only you and your therapist, but other clients who would benefit from the treatment time. In order to conduct business in a most timely, effective, and respectful manner to all parties involved, Set Your Fascia Free, LLC must enact the following cancellation/no show/tardy policy.

1. I will provide Set Your Fascia Free, LLC with a written or verbal cancellation no later than 24 hours prior to my scheduled appointment time. If I do not, I understand that I will incur a fee equivalent to the full cost of the scheduled treatment session(s). If the cancellation or no show is the result of an emergency, the fee will be waived.

2. If I am late to an appointment or must leave early, I understand that I will be treated only for the remaining time and will pay the full session fee.

I have read the above policy and by signing this form agree to pay the cancellation/no show fee if I am unable to provide the appropriate notice for my cancellation/no show.

_____
Signature of patient Date

_____Relationship to patient:_____Date_____
Signature of representative/parent/guardian who is authorized to sign for medical treatment of minor patient

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Privacy Notice

Set Your Fascia Free, LLC respects your right to privacy of your protected health information (PHI). We do not disclose any personal information related to your health to any outside entity unless you tell us to do so or unless the law requires us to do so.
Please read the following information carefully as it pertains to rights and responsibilities of your PHI.
The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

I. **Uses and Disclosures**: We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes:
Treatment: providing, coordinating, or managing health care and related services by one or more health care providers.
Example: We may disclose your health information to another provider (physician, home health agency) if it is necessary to refer you to them for service.
Payment: obtaining reimbursement for services.
Example: We may disclose your health information to a third party such as an insurance carrier, if requested by them in order to reimburse you.
Health Care Operations: include the business aspects of running our practice, including but not limited to conducting quality assessment activities and customer service.
Example: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.
We may use or disclose your PHI in the following situations without your authorization. These situations include emergency situations, as required by law to report on public health issues, communicable disease, health oversight, child abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation research, criminal activity, military activity and national security, worker's compensation, inmates, required uses and disclosures.
With the exception of the above circumstances, any use or disclosure of your health information will be made only with your written authorization. Your written authorization may be revoked, in writing, at any time except to the extent that we have provided services or taken action in reliance on your authorization.
II. Your Rights You have the following rights in regards to your PHI, which you can exercise by providing Set Your Fascia Free, LLC with a written request:
Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions.

Right to Receive Confidential Communications: You have the right to receive confidential communications concerning your health information We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.
Right to Inspect and/or Copy: You have the right to inspect and/or copy certain health information for as long as that information remains in you record.
Right to Amend: You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the request amendment.
Right to Receive an Accounting: You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request.
Right to Receive Notice: You have the right to receive a paper copy of this Notice, upon request.
III. Our Duties We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the PHI that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.
IV. Complaints You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to the address that follows. We will not take any action against you for filing a complaint.

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Set Your Fascia Free, LLC
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By my signature below, I acknowledge the receipt of the notice of privacy practices.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian (to minor)/Relationship to patient Date

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Consent for Electronic Communication

I, _____ understand and consent that Set Your Fascia Free, LLC may communicate with me via electronic means (including but not limited to email, texting, and faxing) for purposes that relate to all aspects of care which may include but are not limited to appointment scheduling, billing, assessment and treatment results, test results, etc. I understand that there are inherent risks in using these forms of electronic communication which may include interception by a third party or transmission to unintended parties.

_____Date:_____

_____Date:_____
Signature of Parent/Legal Guardian (to minor)/Relationship to patient

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COVID-19 Questionnaire and Waiver

In the interest of public health and in providing best care, all new and returning patients are required to complete the following questionnaire and waiver. Please be truthful. If it is determined that you have been or are at risk for exposure to COVID-19, Set Your Fascia Free reserves the right to cancel your session.

Within the last week,

1) Have you or someone you have been in close contact with experienced any symptoms consistent with or been diagnosed with COVID-19 including fever, dry cough, shortness of breath, difficulty breathing, fatigue, body aches, sore throat, runny nose, nasal congestion, diarrhea, new loss of taste/sense of smell. **Y** **N**

2) I am considered high risk. **Y** **N**

Circle those that apply: age over 65, lung compromise/disease, heart disease, autoimmune condition, history of blood clots, diabetes, high blood pressure, liver condition, kidney condition, pregnant/trying to become pregnant

_____ Date:_____
Signature of Patient

Waiver

I understand that COVID-19 is a highly contagious respiratory infection that is potentially life threatening, especially in individuals with the risk factors listed above. I understand that COVID-19 can be transmitted through aerosolized particles, droplets, and/or surface contamination. I understand that therapy sessions require hands-on care and increased physical proximity, in a relatively enclosed environment. I am aware that my therapist may decide to cancel or reschedule if I have been sick, febrile, or have any of the above listed risk factors. I have had the opportunity to ask questions and seek clarification with my therapist. By signing below I agree to each above statement and will not hold Set Your Fascia Free, LLC accountable for any possible risk of unknown/unintentional exposure or harm due to COVID-19.

_____ Date:_____
Signature of Patient