Jamie Duhamel Physical Therapy
1550 Utica Ave Suite LL01, Saint Louis Park, MN, 55416
Phone: (773)495-7218

Physical Therapy Intake

Client Responsibilities

CLIENT RESPONSIBILITIES

By signing this document, you, the client and responsible party (if applicable), agree to the following terms and conditions that will serve as the agreement upon which physical therapy services will be provided to you by Jamie Duhamel PT, L.L.C. (Jamie Duhamel PT, DPT "us" or "we").

YOUR RESPONSIBILITIES

1. Health Information. You have the responsibility for providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health. We may ask you to obtain a written medical clearance from your physician prior to commencing and/or resuming services from us. We reserve the right to withhold further scheduling of services until you are cleared by your physician and proof of such has been provided to us at least 48 hours prior to your next appointment.

2. Treatment Plan. As a client, you have a right to give informed consent and vocalize any pain/discomfort or concerns that you have with the recommended course of therapy. You are an intricate part of your care. Your full participation is required to achieve the desired treatment goals. You also understand that results are never guaranteed. Physical therapy services are strictly confined to the allotted acts that we are licensed to perform is outlined in the MN Board of Physical Therapy Practice Act. (4), as amended, and as further restricted at our sole discretion. Physical therapy services do not include the medical diagnosis of disease or injury, or the use of Roentgen rays and radium for diagnostic or therapeutic purposes.

3. Scheduling/Arrival. It is your responsibility to schedule and attend appointments in accordance with your treatment plan. You are expected to be dressed in appropriate clothing and ready for your appointment five (5) minutes prior to your scheduled appointment time. Appointments will start promptly at scheduled time.

4. Missed/Late Appointments/Cancellations. Your failure to be prepared for your appointment on time will cause the following to occur: 1) your appointment time will not be extended; and 2) you will be billed for a full appointment irrespective of the actual start time. Please provide at least 24 hours notice if needing to cancel an appointment. "No-Shows" will be noted if you are not present and ready within 15 (fifteen) minutes of the agreed upon start time. We reserve the right to discontinue your treatment if you have two (2) no-shows or cancellations with less than 24 hours notice. In the event of inclement weather, we may cancel or reschedule your appointment in the interest of safety.

5. Rates. Rates are subject to change. Current rate: $ 175 Initial Evaluation (90 mins) $125 Follow-up (60 mins)

6. Payment. Payment is due at time of treatment. Services will not be billed through any third- party payor/insurance (Tricare, Blue Cross, Medicare, Medicaid, Workers' Compensation, other health insurance or payors). You will be solely and fully responsible for the charges incurred. We have a strict "no refund" policy. We accept payment by cash or credit card (Visa, Master Card, HSA card etc.). Payment must be received in order to schedule your next appointment. There is a $35 bounced payment fee for payments that cannot be processed which will be assessed to you and due immediately. If a payment plan is needed, details will be agreed on between you and Jamie Duhamel PT, DPT. We reserve the right to

report non-payment to any credit reporting agency. We reserve the right to seek costs of enforcement and collections, including attorneys' fees, from you in the event that your non-payment incurs us such costs. If Client is not responsible for payment, then the "Responsible Party" designated on the signature page of this agreement shall be bound to the terms outlined in this Sections 6 and 7.

7. Limitation of Liability. We are dedicated to preventing further injury and promoting your healing process but this can only be done with your full disclosure and cooperation. By initialing this section, you understand and agree that you are engaging our services for a bona fide medical purpose and have been expressly cleared by a licensed medical doctor to seek out physical therapy services. As such, you are not seeking our services outside of the recommendation of a licensed medical doctor. You have fully disclosed to us all health-related information that is pertinent and necessary for proper treatment. In the event that you have a specific health condition, you have also disclosed the possible ramifications of such condition as it pertains to the structure and integrity of your skeletal, muscular and nervous systems. If necessary, you have provided us with your full medical records including x-rays and MRIs along with the appropriate physician notations to properly explain observations about your specific case. It is your obligation to immediately stop any proposed course of therapy that causes you discomfort or pain and to immediately notify your therapist of such. It is your obligation to immediately stop therapy in the event that you experience an injury—whether in the course of receiving treatment or outside of treatment. Failure to abide by these terms will result in forfeiture of any action or claims that you may seek against us as it relates to services provided to you and shall serve to hold us harmless from any and all such claims.

8. Practice Guidelines. Our goal is to further your health goals. In some cases, therapy may be challenging. We strive to work with you to overcome physical hurdles and frustrations. As such, we expect that our therapists and staff will be treated respectfully at all times. This means that you will be open to your therapist's treatment recommendations and be fully present, without interruption, during your scheduled appointment time. We reserve the right to withdraw from providing you physical therapy services at our sole discretion. For purposes of illustration but not limitation, this may occur if: we discover that you are engaging in or undertaking in a course of action that may be detrimental to your health or treatment plan; you fail to adhere to your therapist's advice; the client-therapist relationship is compromised in any way; communication issues render it difficult for the therapist to perform services; you miss appointments or are consistently late to appointments.

9. Privacy Policy and HIPAA. From time to time it may be necessary for us to use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). By signing this document, you understand that we may call your home or other alternative location and leave a message on voicemail in reference to any items that assist Jamie Duhamel PT, DPT in carrying out TPO, such as appointment reminders and any calls pertaining to my clinical care, among others. Further, we may mail to your home or other alternative location requested by you, any items that assist the practice in carrying out TPO, such as appointment reminder cards and client statements as long as they are marked "Personal and Confidential."

We may e-mail to your home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and client statements.

By signing below, you agree to all of the terms outlined above as a strict condition to obtaining physical therapy services, and further accept full financial responsibility as a client or as the Responsible Party (guarantor) for such client.

Signature

NAME		**Please use your mouse or finger to draw your signature below**	Date

NAME If different than client		**Please use your mouse or finger to draw your signature below**	

HIPPA Policy

Privacy Policies

Jamie Duhamel PT, L.L.C. PRIVACY POLICY

In compliance with Federal Law, The Health Insurance Portability and Accountability Act (HIPAA), Jamie Duhamel PT, DPT , L.L.C. (Jamie Duhamel PT, DPT) is informing you of your privacy rights. Please review the information below.

What is HIPAA?

HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). PHI is confidential information about a patient, including demographic information.

What are my rights under HIPAA?

Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

- You have a right to inspect and obtain a copy of your PHI. We will respond to your request within 30 days. In most cases your request will be honored and a copy of your PHI will be mailed to you.

- You have a right to request an amendment of PHI. If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.

- You have the right to know what disclosure(s) of your PHI have been made. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no
charge to you for an initial request.

- You have a right to request confidential communications of PHI. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.

- You have a right to request restrictions on the use and disclosure of PHI, however we are not required to agree to your request. Your request must state specific restrictions requested and to whom the restrictions would apply.

- You have a right to receive a hard copy of this notice.

How will Jamie Duhamel PT, DPT Use and Disclose PHI under HIPAA?

HIPAA allows us to use and disclose your PHI for the purposes of Treatment, Payment and Healthcare Operations. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of Treatment, Payment and Healthcare Operations (TPO). Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization. Disclosure to those Involved in the Individual's Care when necessary, we will make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve. Uses and Disclosures Required by Law-

As required by law we are required to use and disclose PHI for the following reasons:

Use and Disclose PHI for Public Health Activities - Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials. Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence - Examples include: child abuse and neglect; an abused or neglected nursing home resident; a patient over 60 years old involved in elder abuse. Uses and Disclosure of Health Oversight Activities - We may use and release PHI to be used for audits, investigations, licensure issues, etc. Disclosure for Judicial and Administrative Proceedings - We may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc. Disclosure for Law Enforcement Purposes - We may disclose reasonably necessary PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.

Uses and Disclosures Related to Decedents - We may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law. Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations - We may use and release PHI in order to facilitate organ, eye or tissue donations. Uses and Disclosures to Avert a Serious Threat to Health or Safety - We may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety. Uses and Disclosures for Specialized Government Functions - We may use and release PHI for military/veterans activities and national security/intelligence activities. Use and Disclosure of PHI in Emergency Situations - In the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat. Uses and Disclosures requiring the Patient's Authorization -

We must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations.

You may revoke your authorization at any time.

HIPAA requires Jamie Duhamel PT, DPT must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

By signing below, I hereby acknowledge receipt of Jamie Duhamel PT, DPT Notice of Privacy Practices. Jamie Duhamel PT, DPT will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Jamie Duhamel PT, DPT has reserved a right to change its privacy practices that are described in the Notice.

I also understand a copy of any Revised Notice will be provided to me or made available at my next visit. I give my consent for Jamie Duhamel PT, DPT to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Jamie Duhamel PT, DPT .

Signature

Name		**Please use your mouse or finger to draw your signature below**	
Name if different than patient		**Please use your mouse or finger to draw your signature below**	

Media Release Form

Media Release Form

Media Release Form I hereby authorize Jamie Duhamel PT, DPT LLC and its agents to use, reproduce, and publish photographs, testimonials, statements, and/or video content ("Content") that may contain my image, likeness, and/or voice.

I agree and understand I shall neither be compensated for the Content nor receive attribution for the Content. I also attest that I am authorized to grant to Jamie Duhamel PT, DPT LLC the right to use this Content.

I understand that this Content may be used in publications, press releases, marketing materials, advertisements (both digital and print), websites (including social media sites), or other uses.

This authorization is continuous, and only I may withdraw this authorization through specific, written rescission.

By signing below I hereby release Jamie Duhamel PT, DPT , LLC from any liability of any kind related to the use, reproduction, or publication of the Content.

Signature

Name

Please use your mouse or finger to draw your signature below

Name if different than patient		**Please use your mouse or finger to draw your signature below**	

Physical Therapy Waiver Form

Physical Therapy Waiver Form

This Waiver and Release is between Jamie Duhamel PT, LLC ("Jamie Duhamel PT, DPT) and the undersigned Participant ("Participant") and, if Participant is under the age of 18, the Participant's parent or legal guardian ("Parent").

For valuable consideration, the receipt and legal sufficiency of this is acknowledged by their signatures below. Jamie Duhamel PT, DPT Participant, (and parent) each agree:

Waiver, Release, and Indemnity: By signing this Release; Jamie Duhamel PT, DPT Participant, (and Parent) each waive and assume all risks of participation in physical therapy services and covenant not to bring legal action against **Jamie Duhamel PT, DPT** for any and all bodily harm or other incident relating to treatment by Jamie Duhamel PT, DPT whether on or off Studio U property.

Signature

Name		**Please use your mouse or finger to draw your signature below**	
Name if different than patient		**Please use your mouse or finger to draw your signature below**	

Good Faith Estimate

Date of Good Faith Estimate (GFE))

The date of this GFE is the date in which you it is delivered to you through our portal. The estimated costs are valid for 12 months from the date of delivery.

*We reserve the right for price increases, at which time we will notify you and provide a new GFE.

Understanding your GFE

The GFE is an estimate of your healthcare costs while receiving care with a convening provider at one of our convening facilities.

How does it affect me and why am I asked to sign this?

As of January 1, 2022, all licensed healthcare providers in the U.S. are required to provide estimates for the costs of your care. The Good Faith Estimate (GFE) shows the cost of items and services that are reasonably expected for your healthcare needs and treatment. This will be provided by this office upon scheduling and/or as requested. This Good Faith Estimate does not include unexpected costs that could arise during treatment.

How does this affect billing and payment policies for healthcare with us?

The intent of the law is to protect you from surprise billing and "unexpected surprise charges". We have and will always maintain transparent pricing and simple billing with payment due at time of service without any surprises after this time. We do not send patients a bill. Invoices are always available upon request. We are still required to provide you with this GFE document, by law.

Costs of Services

Good Faith Estimate for Health Care Items and Services Under the No Surprises Act

Physical Therapy Evaluation Cost: $175 and Follow-up Sessions: $125

Your Physical Therapist will determine and expected plan of care and expected number of visits to generate a total estimate

Cancellation and No-Show Policy

Your appointment time is reserved just for you. A late cancellation or missed visit prevents both y and another patient from receiving treatment at that time. As a courtesy to other patients and our providers, we require a 48-hour (or greater) notice for cancellations or changes to your appointment. A cancellation fee equal to the scheduled fee for the appointment will be collected for appointments canceled with less than 48 hours notice.

CPT Codes

CPT codes (Current Procedural Terminology) are used to identify professional services provided and to report those services in a way that can be universally understood by institutions, private and government payers, researchers, and others interested parties. Essentially, this is a number that identifies the type of service received. Your treatment may include sessions that are coded by one or more of the CPT codes listed below. The most common treatment sessions are one hour in length and are billed with 4 units (8-15 minutes each) or codes, which could be 4 units of 1 code (e.g. manual therapy x 4) or 1 unit each of 4 different codes. Either way, the price of the session is the same as indicated above.

Physical Therapy Evaluation

Potential CPT codes could include: 97161, 97162, or 97163 (evaluation of low, moderate or high complexity) or 97164 (patient re-evaluation)

Physical Therapy Follow Up Treatment

Potential CPT codes could include but are not limited to:
97110: Therapeutic Exercise
97112: Neuromuscular Re-education
97113: Aquatic Therapy/Exercises
97116: Gait Training
97140: Manual Therapy
97530: Therapeutic Activities
97535: Self Care Management Training

Estimated Charges

We anticipate that you will require between 4-20 sessions over the course of the next 6-12 months. With a $175 evaluation cost and $125 follow up sessions, your estimated total could be between $550-$2550. The number of visits that are appropriate in your case, and the estimated cost for those services will ultimately depend on your needs and what you agree to in consultation with your physical therapist. This estimate could change depending on your individual condition and your progress during treatment. Additional visits or services could be recommended during your care. We can discuss any potential changes and you may request an updated Good Faith Estimate at any point during your care. The amounts listed above are only an estimate of the cost of services with our providers and our locations and at any point during your care, you may request an updated estimate. This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of sessions with your physical therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here. We believe the therapeutic relationship to be paramount, and we regard your autonomy, right to self-determination, and choice to receive treatment where you will most benefit. It is important that you understand your right to choose your provider based on your unique needs, the provider's specialization, and the right fit.

NOTE: this estimate does not include healthcare cost associated with:

- The cost to see a provider that we have recommended that you see and/or referred you to (e.g. specialty provider such as dietitian, counselor, etc).
- The costs of products sold (which are provided as a convenience to you and are optional)
- The cost of screens or testing (scheduled separately; testing is included with standard PT sessions)
- Late cancelation or no show fees per our policy forms that you will sign as a patient (equal to the scheduled cost of the missed appointment(s))

Expected Frequency and Length of Treatment

We recognize that each patient has a unique treatment journey. Factors affecting your length of treatment may include: your presenting problem, history of presenting problem, stated goals for treatment, challenges and life circumstances, availability to schedule sessions, your support system, age at problem onset, presence of commonly occurring conditions we see in our patients, and others. Our standard practice is to create a treatment plan with each patient's input after the initial evaluation. As progress is made, or if new problems arise, the treatment plan can be revised/updated. We cannot determine without an evaluation what the frequency and length of treatment might need to be. However, the cost of treatment sessions is consistent over time and does not change, as outlined below.

As an example of individual variation in care, one patient with chronic tension headaches may have resolution of symptoms after 4 weekly visits, then have a flare of symptoms 6 months later requiring 2 visits, then report doing well for the rest of the year. Another patient with the same diagnosis might require weekly physical therapy for 4 months in order to improve symptoms. Some conditions such as post operative orthopedic surgeries may require a more predictable number of physical therapy visits but can still have variations based on individual factors. It will become clearer after you have had an evaluation and a few visits what your overall treatment plan is likely to include and we can update your GFE upon request.

Location of Services
For your convenience, we conduct both in-person and virtual sessions. The estimate does not change based on your session being in-person or via telehealth.

Disclaimers: Federal Requirements and Protections

We ask you to sign this form per the requirements of the No Surprises Act. We repeat that this is not a contract, only an indication that you received this estimate and understand the cost of physical therapy services with us. This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill. There is a $25 fee to use the dispute process, and the patient-provider dispute resolution process may be started if the actual billed charges are $400+ more than the expected charges included in the GFE. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 877-696-6775. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 877-696-6775.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount. If

you want your diagnosis updated on this GFE after your assessment, you must let your clinician know.

Signature

Name		**Please use your mouse or finger to draw your signature below**	
Name if different than patient		**Please use your mouse or finger to draw your signature below**	