WildStride Physical Therapy LLC Intake & Consent Packet

Cash-Based Practice | No Insurance Accepted

Website: www.wildstridephysicaltherapy.net

Email: wildstridephysicaltherapy@outlook.com

Phone: 727-273-7414

1. Client Information

Full Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Home Address: _____

Emergency Contact (Name, Phone, Relationship):

_____

2. Medical History & Current Concerns

Reason for Visit / Area of Concern:

_____

Date of Onset: _____

Prior Treatment (PT, Surgery, Medication, etc.): _____

Current Medications:

_____

Relevant Conditions (check all that apply):

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Osteoporosis
- ☐ Thyroid Issues
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ COVID-19 (current or long term)
- ☐ Stroke
- ☐ PTSD
- ☐ Seizures
- ☐ Other:

_____

_____

Allergies: _____

Currently pregnant? ☐ Yes ☐ No ☐ N/A

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3. Therapy Goals & Limitations

What are your goals for therapy?

1. _____

2. _____

3. _____

Activities currently limited or painful: ☐ Walking ☐ Lifting ☐ Working ☐ Driving ☐ Running ☐ Sleeping ☐ Self-care ☐ Sports ☐ Other: _____

4. Cash-Based Practice Agreement

I understand WildStride Physical Therapy LLC is a **cash-based provider** and **does not accept or bill any insurance** on my behalf. I am responsible for full cost of all services rendered at the time of care. A superbill can be provided for self submission, but reimbursement is not guaranteed.

Accepted payments: Cash, Card, Zelle, or approved digital methods.

Initial: _____

5. Cancellation & No-Show Policy

I understand that I must provide **at least a 24 hours' notice** to cancel/reschedule an appointment. Late cancellations and no-shows are charged the **full session fee charge.** Emergency exceptions will be considered on a case-by-case basis.

Initial: _____

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6. Consent to Treat & Assumption of Risk

I voluntarily consent to physical therapy evaluation and treatment from WildStride Physical Therapy LLC and licensed employees. I understand that physical therapy involves the use of hands-on techniques, therapeutic exercises, manual therapy, modalities, and/or education. I recognize that:

- Outcomes are not guaranteed
- I may experience soreness, discomfort, or temporary exacerbation of symptoms
- I am responsible for notifying the provider of pain, concerns, or worsening symptoms
- I may stop treatment at any time
- Potential risks including, but not limited to, soreness or symptom aggravation

I **assume full responsibility** for any known or unknown risks associated with participation. I agree to release and hold harmless Dr. Emily Jones, PT, DPT and WildStride Physical Therapy LLC from any claims arising from participation unless caused by gross negligence or willful misconduct. I understand potential risks, including soreness or symptom aggravation, and voluntarily assume full responsibility.

I release WildStride PT from any claim unless due to gross negligence or misconduct.

Initial: _____

7. Telehealth Consent (If Applicable)

I understand telehealth services may be offered.

- I must be in a private and safe environment
- I am responsible for my own safety during any telehealth exercises
- There are potential privacy risks inherent to electronic communication
- Services may be discontinued if deemed unsafe or ineffective remotely
- I must be in Florida, USA at time of service

Initial: _____

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8. HIPAA Acknowledgement & Privacy Policy

I acknowledge receipt (upon request) and understanding of WildStride Physical Therapy's policy, in accordance with **HIPPA (Health Insurance Portability and Accountability Act)**. My health information will only be used for treatment, billing (if applicable), and operations unless I authorize otherwise. I understand that no information will be released without my written consent unless required by law.

Initial: _____

9. Media & Testimonial Release (Optional)

☐ I consent to allow WildStride Physical Therapy LLC to the use of my non-identifiable image/testimonial/videos for educational or promotional purposes. No personal health details will be disclosed.

☐ I do not consent to the use of my images/testimonials/videos.

Signature: _____ Date: _____

10. Acknowledgment & Legal Signature

I certify that all information I've provided is accurate and complete to the best of my knowledge. I have read, understood, and agree to the policies outlined in this document. I acknowledge that I have the opportunity to ask questions and that participation is voluntary.

Client Signature: _____ Date: _____

Printed Name: _____