Athletic Potential: Performance Physical Therapy
Athletic Potential: Performance Physical Therapy, Kent, WA, 98032
Ph: +1 (636) 208-7866

Athletic Potential: Performance Physical Therapy Intake Documentation

CONSENT

PRIVACY POLICY, CONDITIONS & CONSENT TO TREAT FOR PHYSICAL THERAPY (INCLUDING CONSENT FOR MINOR)

I understand that I am a patient of Dylan Newcomer PT, DPT, CSCS, who is an independent Physical Therapy practitioner who is practicing under and owner of Athletic Potential Performance Physical Therapy, LLC which is housed inside the facility owned by Driveline Baseball Enterprises, LLC.

Cooperation with treatment:
I understand that in order for physical therapy to be effective, I must attend appointments, as scheduled, unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Cancellation/No Show Policy:
I understand the greatest benefit from therapy is with consistent attendance and participation in my plan of care including my Home Exercise Program (HEP). To be courteous to other patients and our therapists, **we require a 24-hour (or greater) notice for cancellations.** I understand that if I cancel more than 24 hours in advance, I will not be refunded my full amount. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of **$50 for the first two appointments, and $100 for the third appointment and beyond that are cancelled within the aforementioned time constraints.** Appointments may be cancelled by phone, text, email, or in person. I understand that if I no-show an appointment without any notice whatsoever I will pay **the full appointment fee AND will not be refunded upon violation of this policy unless the owner agrees to do so in writing to accommodate for any unique circumstances.**

No warranty:
I understand that Athletic Potential Performance Physical Therapy, LLC and Dylan Newcomer PT, DPT, CSCS cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that Dylan Newcomer PT, DPT, CSCS will share with me his professional opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Liability:
I understand and agree that Dylan Newcomer PT, DPT, CSCS, Athletic Potential Performance Physical Therapy, LLC, and Driveline Baseball Enterprises, LLC and its employees are not responsible for loss or damage to personal valuables or personal damages, injuries, or losses that I may incur. I understand and agree that the aforementioned parties are not financially responsible for any of these potential incidents.

Waiver and Release:

I hereby release, discharge and acquit Dylan Newcomer PT, DPT, CSCS, Athletic Potential: Performance Physical Therapy, LLC, and Driveline Baseball Enterprises, LLC and all parties' agents, representatives, affiliates and employees, from any and all liability, claim, demand, damage, cause of action or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services including, but not limited to, ambulance service, emergency medical technician or paramedic services and physician or urgent care services. I understand and agree that the aforementioned parties are not financially responsible for any of these potential incidents or care that I may require from these other medical providers and their services.

Informed consent for treatment:
The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services, and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Athletic Potential Performance Physical Therapy, LLC is exercise-based and, at times, hands-on Physical Therapy. Thorough, highly specialized evaluation and treatment consists primarily of exercise of varying degrees, manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of deep tissue massage, therapeutic exercise programs, therapeutic activities, neuromuscular re-education, myofascial release, bone and soft tissue mobilization, as well as other treatment modalities, may be used. Some of the hands-on treatment techniques require deep pressure, which may cause bruising and periods of increased soreness that could last from 6-72 hours. Your therapist will review your plan of care and discuss these treatment options with you in order for you to provide specific consent. Symptoms may also change and move to other parts of the body. This is not unusual, and it is rarely a concern. However, please ask if you have any concerns or questions. The number of treatments needed and recovery time can both vary due to the duration of injury, number of times injured, age of patient and many other contributing factors.

Consent for a Minor: If physical therapy services involves treatment of a minor, by signing this document below I acknowledge that I am the parent and/or legal guardian and I agree to allow evaluation and/or treatment for my son or daughter by Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC for the initial evaluation and treatments to follow. I understand these services are provided within Driveline Baseball Enterprises, LLC and that the company, facility, or staff are not liable for any injury or losses that may occur as a result of seeking physical treatment for my son or daughter. I understand and acknowledge that my signature below or on any other portion of this document in its entirety, including the PROVIDERS Agreement, Media Release, Communication Waiver, and Covid-19 Waiver, is an acknowledgement that I am the parent and/or legal guardian of the minor to be treated and I agree to the terms listed in the entirety of this document.

If physical therapy services involves delivery of home exercise program or remote training program to a minor, I am the parent and/or legal guardian and I agree to allow the purchased program to be delivered to my son or daughter by Dylan Newcomer PT, DPT CSCS and Athletic Potential Performance Physical Therapy, LLC on the TrainHeroic mobile or desktop application or through the PtEverywhere mobile or desktop application. I understand that there is a chat function within these applications and I agree to allow communication between my son or daughter and Dylan Newcomer for the purposes of monitoring progress, providing assistance in performance of the program including photo/video exchange for purposes of evaluating performance of various exercises, and the exchange of any other relevant information in regards to completing the program to its fullest extent. I understand that If i purchase the "3-Month Unlimited Plan + Monthly Coaching Calls" that my son or daughter will receive a phone or video call in regards to the previously aforementioned communication purposes. I have the right to be present on this call if so desired, but allow my son or daughter to have this phone or video call if I am unable to make myself present. I have the right at any time to deny communication of any kind between Dylan Newcomer and my son or daughter.

Potential risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary. If it does not subside in 24 hours, I agree to contact my physical therapist.

Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the

resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

I hereby give authorization and consent to be treated by Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC for the injury/illness for which I have consulted. In doing so, I voluntarily consent to the rendering of such care within the physical therapy scope of practice by the state of Washington Statutes, in the judgment of my therapist, as deemed necessary. I hereby release liability of Driveline Baseball Enterprises, LLC and any of its employees for use of, or instruction in use of any of the exercise or testing equipment housed within the facility and understand there is inherent risk of injury from use of the equipment.

I understand, acknowledge and affirm that such rehabilitation and related services may involve body contact, touch and/or direct contact of a sensitive nature. I understand that to evaluate my condition, it may be necessary to have **my therapist perform an a hands-on examination for in order to assess the nature of my condition and to provide treatment. This examination is performed by observing and/or palpating various areas of the body and then performing treatment on the identified areas. I understand that I can terminate the evaluation and/or treatment at any time. I understand that if I would like a second person present in the room during examination and/or treatment, then I will provide that person during my session and verbally let my therapist know that.**

I acknowledge that no guarantees have been made to me as the results of examination or treatment by Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC

I understand and agree that Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC provides physical therapy treatment and wellness services for my convenience. I hereby consent to allow Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC to provide such physical therapy and wellness services.

Release of medical records:
I understand and agree that Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC will maintain my privacy to the highest standards and may ONLY use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment involved in my medical care.

I agree that Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.

I have read “Notice of Privacy Practices” as mandated by HIPAA.

I authorize the release of my medical records to my physicians/primary care provider, other medical providers, or insurance companies.

Notification of HIPAA
I acknowledge that I have received or been offered a copy of Athletic Potential Performance Physical Therapy, LLC’s Notice of Privacy Practice, which describes how my PHI is used and shared. I understand that Athletic Potential Performance Physical Therapy, LLC has the right to change this notice at any time. I may obtain a current copy by contacting Athletic Potential Performance Physical Therapy, LLC. My signature below acknowledges that I have been offered a copy or provided with a copy of the Notice of Privacy Practice.

Financial and insurance responsibilities:

I understand the Athletic Potential Performance Physical Therapy, LLC is a fee-for-service clinic and will not bill my insurance company. I agree to pay for my evaluation and treatments at the time of scheduling of service by charge card unless other mutually agreed upon arrangements have been made. I understand Washington is a direct access state and a physician's referral is not required to make an appointment. I understand it is my responsibility to call my insurance company ahead of time and obtain any information that is necessary on my out-of-network benefits, as well as get an estimate of my benefits. I understand my therapist will provide me with a receipt, upon request, that is my responsibility to submit to my insurance company. If further documentation is requested, these will be provided. I understand that Athletic Potential Performance Physical Therapy, LLC does not guarantee I will receive any reimbursement from my insurance company, even if I submit a receipt and/or superbill provided by Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC. I understand and agree Dylan Newcomer PT, DPT, CSCS and Athletic Potential Performance Physical Therapy, LLC does not accept auto accident liens. My signature below acknowledges that I have received a copy and carefully read the terms of the Financial Policy.

TeleHealth Evaluations and Treatments

I have read the above information, and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Please use your mouse or finger to draw your signature below

Relationship to the Patient:

- ○ I am the patient and am 18 years or older
- ○ I am the parent and/or legal guardian of the patient (patient is a minor)

PROVIDERS Agreement

PROVIDERS Agreement

In consideration of the use of the physical therapy evaluation and treatment, training, consulting, coaching, property, facilities, equipment, and/or other services (collectively “Services”) of **ATHLETIC POTENTIAL PERFORMANCE PHYSICAL THERAPY, LLC and DRIVELINE BASEBALL ENTERPRISES, LLC**, their agents, members, owners, officers, volunteers, affiliates, vendors, employees, and all other

persons or entities acting on its behalf, collectively referred to as "**PROVIDERS**", including but not limited to any and all activities involving the Undersigned's participation in physical therapy, manual therapy, performance assessments, weight-training, cardio and aerobic training, running, jumping, throwing of any variation, performance consultation, preventive exercise, stretching, strength-training, or other activities (collectively "**ACTIVITIES**"), the Undersigned does hereby agree as follows:

1. **RISK FACTORS: Undersigned understands and acknowledges that the use of equipment, facilities, and services provided by "PROVIDERS" and the Undersigned's participation in "ACTIVITIES" entails known and unanticipated risks that could result in DAMAGE TO PROPERTY, PHYSICAL OR EMOTIONAL INJURY, PARALYSIS, OR DEATH. The Undersigned understands and acknowledges that such risks simply cannot be eliminated without jeopardizing the essential qualities of Activities.**

2. **ASSUMPTION OF RISK. Undersigned ASSUMES ALL RISKS THAT ARISE OUT OF THE USE OF EQUIPMENT, FACILITIES, OR SERVICES, THE ACTIVITY ITSELF, THE ACT(S) OF OTHERS, OR THE UNAVAILABILITY OF EMERGENCY CARE, including but not limited to, those RISK FACTORS described in Section 1 above. Undersigned acknowledges that participation in "ACTIVITIES" is purely voluntary and Undersigned elects to participate in spite of the risks.**

3. **ACKNOWLEDGMENT OF POLICIES AND PROCEDURES. Undersigned acknowledges reading and knowing all policies and procedures relating to "ACTIVITIES", and any facilities or equipment used by "PROVIDERS", and understands that the safe and proper use of facilities, equipment, or participation in "ACTIVITIES" is dependent upon carefully following such policies and procedures.**

4. **PREREQUISITE SKILLS AND TRAINING. Undersigned acknowledges that he/she has the requisite skills, qualifications, physical abilities, and training necessary for proper and safe use of any equipment, facilities, and to participate in "ACTIVITIES". Undersigned acknowledges and affirms that he/she has obtained pre- approval for "ACTIVITIES" from his/her personal physician, and that "PROVIDERS" may reasonably rely upon such affirmation of ability and approval by Undersigned's personal physician in providing "Services". Undersigned agrees that if he/she has any questions as to what skills, qualifications, or training is necessary to properly use equipment, facility, or to participate in "ACTIVITIES" itself, then he/she shall direct such questions to the appropriate "PROVIDERS" representatives.**

5. **RELEASE. Undersigned RELEASES "PROVIDERS", and hereby agrees NOT TO SUE "PROVIDERS" on account of or in conjunction with any claims, causes of action, injuries, damages, costs, or expenses arising out of "Services" or "ACTIVITIES", including those based on death, bodily injury, or property damage, whether or not**

6. **WAIVER. Undersigned waives the protection afforded by any statute or law in any jurisdiction whose purpose, substance, and/or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving the release does not know of or suspect at the time of executing the release. This means, in part, that the undersigned is releasing unknown future claims.**

7. **INDEMNIFY AND DEFENSE. Undersigned agrees to INDEMNIFY AND DEFEND "PROVIDERS" against and hold it harmless from any or all claims, causes of action, damage judgments, costs or expenses, including attorney's fees, which in any way arise from "Services", "ACTIVITIES", or this Agreement.**

8. **RELEASE OF FACILITIES LIABILITY. For purposes of releases, waivers, liabilities, and indemnities as provided for in this Agreement, Undersigned acknowledges that "Services" and "ACTIVITIES" may, from time to time, be rendered by "PROVIDERS" at facilities not owned, operated, or maintained by "PROVIDERS", and as such, Undersigned releases, waives, and disclaims any rights or causes of action against "PROVIDERS" arising from use of such third-party facilities, including but not limited to operations and maintenance of such facilities.**
9. **CONSENT. Undersigned hereby consents to consultation provided by authorized personnel of "PROVIDERS" as may be dictated by prudent consulting practice.**
10. **INSURANCE. Undersigned agrees and certifies that he/she has adequate insurance to cover any injury or damage that Undersigned may cause or suffer while participating in "ACTIVITIES", or in lieu of insurance that Undersigned will bear the costs of such injury or damage himself/herself.**
11. **REPRESENTATIVES. Undersigned enters into this agreement for himself/herself, his/her heirs, assigns, and legal representatives.**
12. **ACKNOWLEDGEMENT. By signing this document, the Undersigned hereby agrees and acknowledges that if anyone is hurt or property is damaged during his/her participation in "Services" or "ACTIVITIES", Undersigned may be found by a court of law to have waived his/her right to maintain a lawsuit against "PROVIDERS". Undersigned has read and understands this Agreement and realizes it relates to surrendering valuable legal rights and does so freely and voluntarily.**

Please use your mouse or finger to draw your signature below

MEDIA

MEDIA RELEASE

I grant permission to Athletic Potential Performance Physical Therapy, LLC, hereinafter known as the “Media” to use my image (photographs and/or video and written reviews) for use in Media publications including: Videos, Email Blasts, Recruiting Brochures, Newsletters, Magazines, General Publications, Website, Affiliates and Social Media platforms.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image. Please initial the paragraph below which is applicable to your present situation:

I am 18 years of age or older, and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release unless expressed, written denial of this media release is provided.

If the patient being seen is under 18 years of age or older, my signature acknowledge that I am the parent or legal guardian of the patient and that I am competent to contract in my own name and the minor I am providing consent for. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release unless expressed, written denial of this media release is provided.

Please use your mouse or finger to draw your signature below

COVID-19

ASSUMPTION OF RISK AND WAIVER OF LIABILITY RELATING TO COVID-19

The novel coronavirus, COVID-19, and it's variants has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact, and/or by contact with contaminated surfaces and objects, as well as in the air. People reportedly can be infected and show no symptoms, and therefore, spread the disease. The exact methods of spread and contraction are publicly made available by the CDC and WHO, and there is no known treatment or cure. Vaccine for COVID-19 is available but doesn't guarantee that it will not be contracted. Evidence has shown that COVID-19 can cause serious and potentially life-threatening illness and even death.

Athletic Potential Performance Physical Therapy, LLC has put preventative measures in place to reduce the spread of Athletic Potential Performance Physical Therapy, LLC. However, Athletic Potential Performance Physical Therapy, LLC cannot guarantee that you will not become exposed to, contract, or spread COVID-19, while attending a physical therapy appointment. Therefore, if you choose to attend an Athletic Potential Performance Physical Therapy, LLC physical therapy appointment, you may be exposing yourself to and/or increase your risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself in order to attend a Athletic Potential Performance Physical Therapy, LLC physical therapy appointment. These services are of such value to me, that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to attend a Athletic Potential Performance Physical Therapy, LLC physical therapy appointment. If I test positive for COVID-19 within two weeks of attending a Athletic Potential: Performance Physical Therapy, LLC physical therapy appointment, I will notify Athletic Potential: Performance Physical Therapy, LLC who will notify the group that they had a potential exposure.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against Athletic Potential Performance Physical Therapy, LLC, Dylan Newcomer, and Driveline Baseball Enterprises, LLC and its owners, officers, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to attending a Athletic Potential Performance Physical Therapy, LLC physical therapy appointment. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

Mask: At this time, any employee of Athletic Potential Performance Physical Therapy, LLC will wear a mask if requested. You are entitled to your own decision making of wearing a mask or not. We appreciate your understanding during this time.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE.

Please use your mouse or finger to draw your signature below

COMMUNICATION

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Athletic Potential Performance Physical Therapy, LLC respects your right to confidential communications about your protected health information (PHI), as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. We advise that all communications be performed through this patient portal as it contains a HIPAA-compliant messaging system. Please see the Notice of Privacy Practices for more information on your PHI. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text, you are consenting to email and texting communications that may not be encrypted. Voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. Athletic Potential Performance Physical Therapy, LLC will not be responsible for any privacy or security breaches that may occur through voice or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

○ I DO CONSENT ○ I DO NOT CONSENT

I DO consent to all communication, including but not limited to, communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):

☑ Email

☑ Text

☑ Voicemail

Name (First & Last)

Please use your mouse or finger to draw your signature below

Financial Policy and Insurance Information

Financial Policy and Insurance Information - Payers Agreement

Thank you for choosing Athletic Potential Performance Physical Therapy, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment: Full payment is due at the time of scheduling and/or prior to delivery service; Initial Physical Therapy evaluation with treatment $240.00; all following visits $150.00. Prices are subject to change at the owner, Dylan Newcomer's, discretion.
- **Waiver of Confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.
- Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- Missed Appointments and Late Cancellations: I value your time and request that you value mine. The first two appointments not kept, cancelled, and/or rescheduled within 24 hours prior to the scheduled appointment time will be charged $50.00 each. The third and all subsequent appointments not kept, cancelled, and/or rescheduled within 24 hours prior to the scheduled appointment time

will be charged $100.00 each. These charges will be your responsibility. You will be notified of your missed appointment and charges to your account within 48 hours. Missed appointment fees must be paid prior to the next scheduled appointment.

- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

- **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are ***not*** enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and many of the post-rehab services or fitness/wellness we offer are not covered by Medicare. Since we are not enrolled providers, we cannot submit claims to Medicare ***and*** Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. Therefore, by choosing our services, you are exercising your right to privacy and electing, of your own free will, not to use your Medicare benefits. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

  - **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.
  - **Medicare Advantage Plans and Medicare Replacement Plans.** We are not in-network with any Medicare Advantage or Replacement Plans. If your Medicare Advantage or Replacement Plan offers out-of-network benefits for services received from providers not enrolled with Medicare and we don't have to directly submit your claims, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, you should be prepared that your health plan may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your health plan to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
  - **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.

- **Wellness & Fitness Services.** Most commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request. Remote Performance Training is dependent on your individually selected plan ranging from $50-$300/month per selected plan OR $800 for the 3-month unlimited plan. Prices are subject to change at the owner, Dylan Newcomer's, discretion.

- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your

services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

- **Service Termination Policy.** If we determine at any time that conditions in your home create a potentially unsafe environment for our providers, we may, at our sole discretion, terminate our services with you. If we do so, we will make reasonable efforts to refer you to the services you need to resolve the issue that is causing a potentially unsafe environment. If you have prepaid for any services, we will refund any monies paid for services not yet received as of the date or our termination.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Athletic Potential: Performance Physical Therapy, LLC and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Athletic Potential Performance Physical Therapy, LLC and my therapist, Dylan Newcomer, from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

Please use your mouse or finger to draw your signature below