FULL CIRCLE THERAPY, PLLC

215 Wellington Way, Smyrna, TN 37167 * 615-545-4271* F800-517-3873* Fullctherapy@aol.com* www.fullcircletherapy.org

I hereby grant my permission for the above named person to receive treatment services at Full Circle Therapy, PLLC, in the form of (circle or shade those that apply) PT. I have received a copy of the Patient's Rights, TitleVI, and the HIPPA privacy statement. Also, I understand the nature of services that will be received. By signing below, I acknowledge the policies of Full Circle Therapy, PLLC and my responsibilities as stated below:

Authorization for Emergency Medical Treatment:
In the event of an emergency or medical aid or treatment is required due to illness or injury, while under the care of Full Circle Therapy, PLLC, I authorize Full Circle Therapy, PLLC to secure and retain medical treatment (x-ray, surgery, hospitalization, life saving measures, etc.), and/or transportation, and/or to release any pertinent medical records to the emergency personnel, and/or to contact my emergency contact(s).

Consent to photograph, video tape, sound record, and/or televise:
I hereby give Full Circle Therapy, PLLC the right to photograph, video tape, sound record, and/or televise the actions and utterances of the patient/client listed above and to use any descriptive words deemed necessary, including the above patient/client name. I hereby give up my rights to any of the above listed material and I understand that it may be used in promotional material (websites, u tube, social media sites, e-mail, advertisements, etc.) and media releases.

Medical Information Authorization:
I hereby give my consent for any physician, hospital, school, and/or clinic to release any and all records pertaining to medical history, services, and/or treatment, as it applies to my treatment at Full Circle Therapy, PLLC. This information will be treated as confidential under the privacy practices act. I also give Full Circle Therapy, PLLC permission to release information to my funding source, my physician, my school, their assistants/aides/volunteers, and/or other agencies that I may designate, and/or the parties listed on this consent form. I have received my HIPPA rights and my patient rights and my title VI rights.

Financial Responsibilities: All contracted service recipients (waiver, health and wellness, school based) are not financially responsible, unless they agree to services that are over and above the contracted rate.

The undersigned assumes financial responsibility for services received from Full Circle Therapy, PLLC, unless this is a contracted service recipient. I understand that if there is no contracted provider listed above, that I am solely responsible for paying for the services.

Private therapy is held at the rate of $30 per 15-minute unit (with a $60 minimum per visit charge) at the time that the services are rendered.

Further, I understand that Full Circle Therapy, PLLC may provide me with documentation to submit to my insurance carrier or funding source. I understand that all claims are non-assigned and that Full Circle Therapy, PLLC is out-of-network with all providers; therefore, the out-of-network rates, deductibles and co-pays apply. Submission of a claim does not guarantee payment. I understand that Full Circle Therapy, PLLC makes no promises regarding payment for services rendered. I also understand that I am financially responsible regardless of reimbursement. I hereby grant Full Circle Therapy, PLLC permission to cash any insurance checks received and to reimburse me out of the Full Circle Therapy, PLLC account; however, if the insurance company ever seeks reimbursement back from Full Circle Therapy, PLLC or from me on my claim; then I agree to pay the amount back to the insurance company and/or to reimburse Full Circle Therapy, PLLC for the insurance claim. Finally, I understand that there is a $30 returned check fee.

Cancellations/Tardiness:
I also understand that Full Circle Therapy, PLLC can enact a $30 account charge for any cancellation/no shows without prior 24-hour notification. I also understand that if I am tardy by 15 minutes or more Full Circle Therapy, PLLC reserves the right to cancel my appointment session.

Release Agreement:

I do hereby forever release, acquit, discharge, and hold harmless Full Circle Therapy, PLLC, their officers, trustees, agents, employees, volunteers, representatives, successors, students, or assigns for all manner of claims, demands, damages of every kind and nature to potentially include but not limited to personal injury or loss, physical or mental conditions, known or unknown, as a result of any act of Full Circle Therapy, PLLC, including but not limited to negligence/gross negligence in the delivery of any services.

I also acknowledge the risks associated with horseback riding, if the patient with be receiving hippotherapy, and I feel that the possible benefits are greater than the risk assumed. I understand the TN Equine Liability Law, which states: Under Tennessee Law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Tennessee Code Annotated, title 44, chapter 20.

I also acknowledge the risks associated with aquatic therapy/pool activities, if the patient with be receiving aquatic therapy, and I feel that the possible benefits are greater than the risk assumed.

Privacy Rights:
You have the right to request a copy of your HIPPA rights and as of 1/1/2011 you understand that they are available to you at www.fullcircletherapy.org.

Patient Rights:
You have the right to request a copy of your Patient Rights and as of 1/1/2011 you understand that they are available to you at www.fullcircletherapy.org.

Title VI:
Full Circle Therapy, PLLC does not discriminate in any way on the basis of race, color, or national origin. You have the right to request a copy of your Title VI rights and as of 1/1/2011 you understand that they are available to you at www.fullcircletherapy.org.

The undersigned certifies that he/she has read and understands the foregoing and has received a copy. You have the right to request a copy of your Patient Consent Form and as of 1/1/2011 you understand that they are available to you at www.fullcircletherapy.org.

The undersigned certifies that he/she is the patient/client or is the duly authorized parent/guardian/conservator and can execute the above and accept its terms on behalf of the patient.

Jennifer Allen, DPT, HPCS, President (Full Circle Therapy, PLLC Agent)