Client Welcome Information

Welcome to StephanieTeranPT! Starting a new therapy is exciting, but it can also be filled with anxiety, uncertainty, fear and lots of questions. Please read this for answers to your questions about what to expect as we start your journey toward moving,feeling and living better!

Before your first visit

● Print and sign the “New Client” forms found under “Forms” at the top of the stephanieteranpt.com website homepage. Bring these forms with you to your appointment. You can also sign the forms at the office if you prefer.
● Drink extra water to be well hydrated, especially if you are coming for Fascial Stretch Therapy or Dry Needling. This is thirsty work and being hydrated will be very helpful in allowing your tissues to respond to the therapy.
● Dry Needling clients, be sure to review and bring the signed “Dry Needling Information and Consent” form.

What to wear

● Wear comfortable, loose and/or stretchy clothing that allows movement throughout your entire body. Shorts, leggings, sweat pants, or joggers on the bottom. T-shirt, cami, tank top, or sports bra on the top.
● Athletic shoes are a good idea.
● If you are having Dry Needling, make sure we have access to your skin.
● You may bring clothes to change into at the office.

Payment

● StephanieTeranPT is a private pay/fee for service practice. This allows you to receive great value for your time and money. Your therapy will always be one-on-one with a licensed Physical Therapist, comprehensive, customized for you and of the highest quality.
● Cash or check payments are preferred. Debit/credit cards are also accepted.
● We are not contracted providers with any insurance companies, including Medicare. By law we may provide wellness, fitness, and flexibility based treatments to Medicare beneficiaries. However if you have a specific injury or condition that would be covered by Medicare, we will be happy to refer you to a Medicare provider PT, or call the office at (520) 312-6954 and we can talk about it.
● You will receive a detailed superbill that you can use if you choose to submit a claim for out-of-network reimbursement to a (non-Medicare) insurance company.

Reviews

● Your feedback about your experience at StephanieTeranPT is important to us! If you are not completely satisfied, we want to know about it and how we can better help you and improve our services.
● Reviews on social media are very appreciated. Or send an email or letter and we will add it to our patient testimonials if you agree.

And, last but not least…

Cancellation and No-Show Policy

● Your appointment time has been reserved for you. Cancellations must be received 24 hours prior to the scheduled appointment to avoid a charge of up to the full amount of the service.
● Please call or text if you are running late so everyone's time can be optimized.

Please sign and date below to confirm that you have read and understand and agree with every single thing on this document.

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Client signature (or parent/guardian of minor) Date

About You

Your Name____________________ When were you born?__________ Today's Date_________
Your Address____
Phone number____________________ Email Address_________________________________
Can we text & email you? (StephanieTeranPT will not share or sell your info) Yes No thanks, just call
Emergency contact name & phone #____
Primary Physician____________________________ Phone number______________________
What are your goals for this therapy? What's bothering you?
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____
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Medical HIstory:
Current conditions/injuries:
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Previous injuries/surgeries/medical conditions:
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Please list all medications and supplements you are taking: (or attach list)
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Consent: I consent to the evaluation and treatment by my therapist. My therapist will explain the purposes of the evaluation and course of treatment, and inform me of expected benefits, risks and

appropriate alternative treatments.

Signature_______________________________ Date Signed_____________

Parent/guardian signature (if client is a minor)_________________ Date Signed _____________

Privacy Notice and Acknowledgement

StephanieTeranPT, LLC respects your right to the 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 the rights and responsibilities of your PHI.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires 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 rights to understand and control how your health information is used. HIPPA 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 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 diseases, 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 StephanieTeranPT, 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 your 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 health information must be made in writing to our Privacy Official and you must provide a reason to support the requested 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.

Stephanie Teran, PT
StephanieTeranPT, LLC

By my signature below, I acknowledge the receipt of the Notice of Privacy Practices.

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Signature of Patient (or Parent/Legal Guardian of minor) Date