Bout2bebetter Physical Therapy Inc.
Jennifer D. Johnson, DrPH, PT, CSCS
Doctor of Public Health, Physical Therapist, Certified Strength & Conditioning Specialist

Release and Waiver

This Release and Waiver ("Release") is made and provided by the person signing below ("Participant"), who participates and engages in the activities listed below at the property located at 24 N. First Avenue, Arcadia, CA 91006 ("Premises"). WHEREAS, the Participant desires to enter the Premises for Physical Therapy assessment and / or treatment, Personal Training, Functional medicine consultation, and / or Functional mobility assessment (collectively, the "Activities"). WHEREAS, Participant acknowledges and agrees that entering into this Release is required as a condition to entering and/or using the Premises and participating in the Activities.
WHERAS, this Release shall be effective on the date of its execution and delivery by Participant.
For good and valuable consideration, including but not limited to being provided access to and use of the Premises, the undersigned, on behalf of themselves and any minor children named below, hereby stipulate and agree:

1. ACKNOWLEDGMENT AND ASSUMPTION OF RISK. Participant understands and acknowledges that the Activities that take place on the Premises may be dangerous and may involve the risk of sustaining injury, temporary or permanent disability, death, and/or property damage. Participant understands and acknowledges that the Activities that take place on the Premises may not be supervised and that the Released Parties (as defined in Section 3 of this Release) do not provide medical services. Participant also acknowledges that any injuries he or she may sustain may be compounded or increased by negligent or delayed medical service. Participant further acknowledges there may be other risks and economic losses, which may be known to the Participant or may be unforeseeable, that are presented by participation in theEvent.

PARTICIPANT VOLUNTARILY AND FREELY ASSUMES ALL RISKS AND DANGERS THAT MAY OCCUR PURSUANT TO ENTRY ONTO THE PREMISES AND PARTICIPATION IN THE ACTIVITIES ON THE PREMISES, INCLUDING THE RISK OF INJURY, DEATH, OR PREMISES DAMAGE.

2. PARTICIPANT'S REPRESENTATIONS. Participant acknowledges and represents that: (1) Participant understands that it is his or her responsibility to or has had the opportunity to consult with a licensed physician who has approved his or her participation in the Activities; (2) Participant shall inform the Released Parties of all known medical conditions, injuries and/or medications, as well as any changes in my health and medications; (3) Participant will not consume or be under the influence of any alcohol or drugs at any time while on the Premises and (4) Participant has fully read and understands each of the provisions of this Release, and prior to signing this Release had the opportunity to consult with an attorney.

3. RELEASE FROM LIABILITY. Participant hereby agrees, on behalf of himself or herself, and his or her heirs and personal representatives, to fully and forever discharge and release owner of the Premises, their affiliates, and their respective partners, agents, operators, managers, employees, and representatives, and other participants ("Released Parties") from any and all claims Participant may have or hereinafter have for any injury, temporary or permanent disability, death, damages, liabilities, expenses, costs, and/or causes of action, now known or hereinafter known in any jurisdiction in the world, attributable or relating in any manner to Participant's entry upon the Premises and participation in the Activities, whether caused by the negligence of the Released Parties or by any other reason. Participant acknowledges and agrees that this Release is intended to be, and is, a complete release of any

responsibility of the Released Parties for any and all personal injuries, temporary or permanent disability, death, and/or Premises damage sustained by the Participant while on the Premises or in any way related to the Activities.

4. COVENANT NOT TO SUE. Participant agrees, for himself or herself, and all of his or her heirs and legal representatives, not to sue the Released Parties or initiate or assist in the prosecution of any claim for damages or cause of action against the Released Parties which Participant or his or her heirs or legal representatives may have as a result of any personal injury, death or Premises damage the Participant may sustain while on the Premises or participating in the Activities.

5. INDEMNIFICATION. Participant hereby agrees to defend, indemnify and hold harmless the Released Parties from and against any third party losses, damages, actions, suits, claims, judgments, settlements, awards, interest, penalties, expenses (including reasonable attorneys' fees) and costs of any kind for any personal injury, loss of life or damage to Premises sustained by reason of or arising out of Participant's involvement in any of the Activities or Participant's use of the Premises, whether caused by the negligence of Released Parties or otherwise.

6. Governing Law and Venue. This Release agreement will be governed by and interpreted in accordance with the laws of the State of California, without giving effect to the principles of conflicts of law of such state. Participant agrees that any action arising out of this Release must be brought exclusively in any state or federal court located in California, Los Angeles County.

7. Waiver. No waiver of any term or right in this Release shall be effective unless in writing, signed by an authorized representative of the waiving party. The failure of any party to enforce any provision of this agreement shall not be construed as a waiver or modification of such provision, or impairment of its right to enforce such provision or any other provision of this agreement thereafter.

8. Survival. Any provision of this Release providing for performance by either party after termination of this agreement shall survive such termination and shall continue to be effective and enforceable.

9. Compliance with Laws. In the performance of the terms of this Release, use of the Premises and participation in the Activities, the parties shall comply with all applicable federal, state, regional and local laws, rules and regulations.

10. Severability. If any provision or portion of this Release shall be held by a court of competent jurisdiction to be illegal, invalid, or unenforceable, the remaining provisions or portions shall remain in full force and effect.

11. Entire Agreement; Modification; Binding Effect. This Release is the entire agreement between the parties with respect to the subject matter hereof and supersedes any prior agreement or communications between the parties, whether written, oral, electronic, or otherwise. No change, modification, amendment, or addition of or to this agreement shall be valid unless in writing and signed by authorized representatives of the parties. This agreement shall be binding upon and inure to the benefit of the successors, assigns, and legal representatives of the parties.

I HEREBY ACKNOWLEDGE THAT I HAVE FULLY READ AND UNDERSTAND EACH OF THE ABOVE PROVISIONS. I ACKNOWLEDGE THAT PRIOR TO SIGNING THIS AGREEMENT I HAD THE OPPORTUNITY TO CONSULT WITH AN ATTORNEY TO REVIEW THIS AGREEMENT. I UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING THIS AGREEMENT, AND ENTER THIS AGREEMENT FREELY AND VOLUNTARILY.

Participant's Signature: ____ Date: ______________

Participant's Printed Name: ____________________________________ Date: ______________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to: Make sure that protected health information ("PHI") that identifies you is kept private. Give you this notice of my legal duties and privacy practices with respect to health information. Follow the terms of the notice that is currently in effect. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and / or on my website.
HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories. For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a health care provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the health care provider in diagnosis and treatment of your condition. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another. Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: 1. Session Notes: I do keep "Session notes" and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising associates to help them improve their clinical skills. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the session notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others. 2. Marketing Purposes. As a health care provider, I will not use or disclose your PHI for marketing purposes. 3. Sale of PHI. As a health care provider, I will not sell your PHI in the regular course of my business.

CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION: Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons: 1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law. 2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety. 3. For health oversight activities, including audits and investigations. 4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so. 5. For law enforcement purposes, including reporting crimes occurring on my premises. 6. To coroners or medical examiners, when such individuals are performing duties authorized by law. 7. For research purposes, including studying and comparing the patients who received one form of care versus those who received another form of care for the same condition. 8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions. 9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws. 10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT: 1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI: 1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care. 2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.

You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full. 3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests. 4. The Right to See and Get Copies of Your PHI. Other than "session notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request. 6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on: (today's date):__________________

Acknowledgement of Receipt of:
Privacy Notice Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Client Name:__________________________ Client Signature: _________________________________ Today's date: __________

PRACTICE POLICIES APPOINTMENTS AND CANCELLATIONS

Please remember to **cancel or reschedule 24 hours in advance**. You will be responsible for the **entire fee** if cancellation is less than 24 hours. The standard meeting time for Physical Therapy / Functional Medicine / Personal Training Services is 60 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 60 minute session needs to be discussed with the health care provider in order for time to be scheduled in advance. A $25.00 service charge will be charged for any checks returned for any reason for special handling.
Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.
TELEPHONE ACCESSIBILITY If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.
ELECTRONIC COMMUNICATION I cannot ensure the confidentiality of any form of communication through electronic media, including text messages, and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. I prefer to communicate via secure messaging on the Patient Ally platform for issues regarding scheduling or cancellations, and all communication regarding clinical information. While I may try to return messages in a timely manner, I cannot guarantee immediate response.
Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that: You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. 2. All existing confidentiality protections are equally applicable. 3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. 5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to treatment, better continuity of care, and reduction of lost work time and travel costs. Effective treatment is often facilitated when the healthcare provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. The provider may make assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in services, potential risks include, but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically potentially. Effective treatment is often facilitated when the healthcare provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. The provider may make assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in services, potential risks include, but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the provider not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the provider. MINORS If you are a minor, your parents may be legally entitled to some information about your treatment. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential. TERMINATION Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the treatment is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason or you request another provider, I will provide you with a list of qualified Physical Therapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client signature: ____ Date: _________________

Release of Information

Client Name: ____

I authorize Bout2bebetter Physical Therapy Inc. to Send AND receive the following information:

______Medical history and evaluation (s)

______Progress notes

______Radiology reports

____

To: Bout2bebetter Physical Therapy Inc.
From: ____
Phone: ____
*The above information will be used for the following purposes:
_____Planning appropriate treatment or program
_____Continuing appropriate treatment or program
_____Determining eligibility for benefits or program
_____Case review
_____Updating files
_____Other: ____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and not a condition for treatment, payment, enrollment or eligibility for benefits, and I may revoke this consent at any time by providing written notice, and after
(some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Direct Physical Therapy Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon’s certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist’s plan of care indicating approval of the physical therapist’s plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Client name: _______________ Client signature: ______________________ Date: _______________

Informed Consent and Release: Videos and Pictures

This Informed Consent and Release (“Agreement”) is entered on [DATE], by Bout2bebetter Physical Therapy Inc.(“Company”) and [NAME OF CLIENT] (“Client”).

Client hereby authorizes Company, or agents acting on their behalf, to photograph and / or videotape Client in Company’s sole discretion. Client irrevocably grants to Company an exclusive, worldwide, royalty-free, transferable, perpetual license to access,

display, publish, reproduce, distribute, and otherwise use and reuse the results and proceeds of Clients's involvement hereunder, along with Client's name, image, voice, likeness, photographs, videotaped recordings, audio recordings, biographical information, and any other personal characteristics or lines (collectively, the "Materials") in any media
(now or hereafter known), for strict purposes of mentorship in residency / fellowship programs, course, social media promotion, or online presentations. Company shall not use the Materials for marketing purposes unless Client consents to such use (see below).
I consent to the use of Client's name, image, voice, likeness, photographs, videotaped recordings, audio recordings, biographical information, and any other personal characteristics or lines (collectively, the
"Materials") for marketing purposes.
This authorization is effective immediately and may be revoked in writing by the undersigned at any time. Written revocation will not affect any action taken in reliance on this authorization before the written revocation is received.
Client Name: ____________________________ Client Signature: __________________________________ Date: ____________________

Credit Card Authorization & Payment Info

__________Recurring charge- I authorize Bout2bebetter Physical Therapy Inc. to make regularly scheduled charges to my Credit Card to cover the cost of services rendered as determined upon insurance eligibility and benefit verification. Costs may include a co-payment, and / or a co-insurance amount as determined by my insurance carrier. If I have a deductible, and my deductible applies, I agree that I am responsible for a full visit until my deductible is satisfied. A receipt for each payment will be available to me at the secure patient portal, and the charge will appear on my Credit Card statement.
I ____ authorize Bout2bebetter to charge my Credit Card for services rendered.
I ____ authorize Bout2bebetter to charge my card for a full visit for any visit that is not cancelled or re-scheduled 24 hours prior to my scheduled appointment.

___________Ongoing charge: I give Bout2bebetter permission to debit my account for ongoing transactions that I authorize either verbally, or through message correspondence on the Simple Practice platform.
____ I understand Bout2bebetter will NOT make any transactions without my prior authorization.
I ____ authorize Bout2bebetter Physical Therapy Inc. to maintain my Credit Card information on secure merchant / practice management platforms: Stripe / Simple Practice.
I ____ authorize Bout2bebetter Physical Therapy Inc. to charge my
Credit Card on file.

Credit Card Info

Health Savings Card Visa Mastercard Discover
Cardholder's Name: ____ Credit Card Number:
____________ - ______________ - ______________ Expiration: _____________ Security Code (CCV): _________________
Individual's Signature: ____ Date: _______________