DR. REAMS
CONCIERGE PT LLC

Release of Information:

Dr. Reams Concierge PT LLC is authorized to release pertinent medical information to your referring physician.

Dr. Reams Concierge PT LLC is authorized to release Dr. Reams scheduled location and current location for safety purposes only.

Privacy:

The HIPAA rules concerning protected health information do not apply to Dr. Reams Concierge PT LLC because it is a concierge practice that does not conduct electronic transactions with health plans or other electronic transactions covered by the HIPAA rules. Nonetheless, Dr. Reams Concierge PT, LLC does take reasonable steps, in accordance with Tennessee law, to protect the privacy and security of its patients' health information.

Guarantee of Payment/Financial Responsibility/Insurance:

Payment is due at the time of service.
I agree to pay Dr. Reams Concierge PT LLC in full at the beginning of each treatment session, unless otherwise agreed upon by both parties in writing.
I understand that any outstanding balance is my/our responsibility. I agree to pay the balance within 14 days of receipt of invoice (unless a payment plan has been discussed and agreed upon beforehand).

Cancellations:

I understand that if I am unable to attend a scheduled appointment, I am required to cancel the appointment by email or call Kalie Reams PT, DPT 12 hours prior to the said appointment; otherwise a fee of 50% of the agreed

appointment fee will be incurred for late cancellations. This 50% rate fee is required because another patient, who needs treatment, could have been scheduled and treated in this time slot.

Mask:
I agree to wear an approved face covering during evaluation and treatment while within 6 feet of treating therapist or the appointment will be terminated without a refund.

<u>Consent:</u>

By signing my name below, I verify that I have read and agree to the information contained in this packet
and that the information I have provided is true and accurate.

Patient's signature (Or, responsible party if the patient is a minor or unable to sign. Please include relationship.)

_____
Patient's signature

Date: _____