Free Consult Liability Release,
Financial Responsibility, and Policy Form

1. Action Potential, LLC (“Action Potential”) agrees to provide physical screen services to the undersigned Participant (services being referred to herein as the “Program”) conditioned upon the Participant signing his/her Release.

2. Participant acknowledges and agrees that Participant’s participation in the Program is to screen for physical status and is not deemed skilled physical therapy. It is the Participant’s responsibility to consult with a physician prior to performing the Program if he has any concerns regarding his physical health. Participant should follow any restrictions placed on Participant’s activity by Participant’s physician. Action Potential is not responsible for Participant’s failure to consult a physician or follow physician’s orders.

3. Participant is aware that exercise and the equipment and facilities in which these activities are carried out involves risks and perils, including risk of injury and death, and Participant assumes such risks. Participant expressly agrees and understands that all exercise and participation in the Program shall be at Participant’s own risk and that Action Potential, its officers, directors, agents, and employees shall not be liable for any claims, demands, injuries, damages, actions or causes of action whatsoever to person or property arising out of or connected with Participant’s participation in the Program. In consideration of Participant’s participation in the Program, Participant hereby expressly releases, discharges, and holds harmless Action Potential, its officers, directors, agents, and employees, from all claims, demands, injuries, damages, actions or causes of action arising out of or connected with Participant’s participation in the Program.

4. Participant has chosen to participate in a physical screen and will incur no cost for this screen. Upon completion of the screen, Participant will be provided results of screen and advised on appropriate course of action, if necessary.

____   _______________
Print Participant Name (and Representative/POA if applicable)   Date

____
Participant Signature (and Representative/POA if applicable)

Action Potential
One on One Physical Therapy

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Action Potential, LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: Attn: Compliance Officer, Action Potential, 1786 Wilmington Pike, Suite 200A, Glen Mills, PA, 19342.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

   ____

   ____

5. I authorize the Practice, to disclose my health information that is directly related to my current treatment to the individual(s) listed below:

   ______________________________ ______________________________
   Name of Individual(s) Relationship to Client

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

______________________________ ______________________________
Signature of Client or Representative Date

____
Client's Printed Name

____
Client's Date of Birth

______________________________ ______________________________
Printed Name of Representative (if applicable) Relationship to Client

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