jennifer richards little mpt cst

508.932.3086
jen@jenniferrichardslittle.com

27 Longfellow Road
Natick, MA 01760

NAME: **Preferred pronouns (please circle):** **she/her/hers; he/him/his; they/them/theirs; ze/hir/hirs; xe/xem/xyrs**	**BIRTHDAY:**	**TODAY'S DATE:**
ADDRESS:	**PHONE:** **text appointment reminders: yes/ no**	
TOWN:	**STATE:**	**ZIP:**
EMAIL: **You will automatically be added to the clinic email list and can unsubscribe at any time.**		
REFERRED BY: **Ok to send them a thank you for the referral? yes/no**		

HOW CAN I HELP?

My Story is…(please include any relevant dates)

MY SYMPTOMS ARE:

PHYSICAL I feel in my body… Pain: Dysfunction:	EMOTIONAL I'm worried that….. My emotions are focused around…	MENTAL My brain is working: normally fast slow foggy Other: My thought patterns are focused around...

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I MANAGE THESE SYMPTOMS WITH:
CBD/ Marijuana/ Alcohol / Prescription Medications / Other

THE MEDICATIONS I TAKE ARE:

MY NOURISHMENT PATTERNS ARE:

PHYSICAL	EMOTIONAL	MENTAL
I move my body by: I eat: no restrictions I avoid: I sleep: without issue I struggle with sleep:	I do/do not let myself feel my emotions. I long to feel… I sometimes feel stuck in the emotion of...	I do/ do not struggle to manage my time. I do/ do not struggle to get things done. My thoughts are clear and focused all/ some/ none of the time.

MY HISTORY IS SIGNIFICANT FOR:
Me: medical conditions:
surgeries:
injuries:

Parents/ Siblings:

MY ENVIRONMENT IS:
Home: new/old construction; does /does not contain mold; good/ poor air filtration; safe/ not safe relationships
Work: my work station set up is comfortable/ uncomfortable; my job duties consist of: standing /sitting/ lifting/ driving/ typing; other:

MY GOALS ARE:

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CONSENT TO TREAT

I hereby request and consent to the performance of treatments and other procedures within the scope of the practice of integrated manual therapy on me (or on the patient named below, for whom I am legally responsible) by the physical therapist named below and/or other licensed therapists who now, or in the future, treat me while employed by, working or associated with, or serving as back-up for the therapist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, CranioSacral Therapy, Myofascial release techniques, lymphatic drainage massage, visceral fascial release techniques, Swedish massage, deep tissue massage, trigger point therapy, stress reduction techniques, injury rehabilitation techniques, pre-natal and post-natal techniques, energetic work, body awareness work, postural techniques, sports massage techniques, facilitated stretching techniques, and corrective exercises.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records, but all my records will be kept confidential and will not be released without my written consent.

I, the undersigned, hereby expressly and affirmatively state that I wish to participate in physical therapy. I realize that my participation in this activity involves risks of injury including but not limited to: cardiovascular and orthopedic type injuries, serious disabling injuries, and even the possibility of death. I also recognize that there are many other risks of injury that may arise due to my participation in this activity, and that it is not possible to specifically list each and every individual injury risk. However, knowing the material risks and appreciating, understanding, and anticipating that other injuries and even death are a possibility, I hereby expressly assume all of the delineated risks which could occur by reason of my participation. I have had an opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I subjectively understand the risks of my participation in this activity, and I voluntarily choose to participate, assuming all risks due to my participation.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE (Or Patient Representative – indicate relationship if signing for patient)

Date

PRACTITIONER SIGNATURE

Date

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NOTICE OF PRIVACY RIGHTS AND PRACTICES

(Effective May 1, 2020)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE ASK TO HAVE THIS FORM TRANSLATED FOR YOU TO ENSURE YOU UNDERSTAND ITS CONTENTS. PLEASE REVIEW IT CAREFULLY.

As of April 14, 2003, I am required under the Health Insurance Portability and Accountability Act (HIPAA) and currently under Massachusetts law to maintain the privacy of your health information, and to provide you with this Notice of Privacy Rights and Practices if requested.
This document explains in detail how I use your Protected Health Information (PHI) which is any information about you that could identify you, your past, present, or future physical or mental health condition(s). Your acknowledgement of receipt of this document will be required the first time you receive services after April 14, 2003.
Examples of how we can use and disclose your information without your authorization include: Treatment, Payment, Health Care Operations.

I keep a record of each visit. These records may include your test results, diagnoses, medications or other therapies. These records are used and disclosed to allow doctors, nurses, therapists and other healthcare and clinical staff providers to offer high quality care to meet your needs.

I use and disclose your medical information to improve the services I provide, to train staff and students, for business management – including marketing, and for customer service purposes.

Your information may be shared amongst my staff, other health care providers, third party payers, and our Business Associates to facilitate treatment, payment or health care operations.

ADDITIONAL USES AND DISCLOSURES:
There are additional times when I am permitted or required to use and/or disclose medical information without your permission. These circumstances are listed below:

- In emergency treatment situations
- To assist uncommunicative patients
- For organ donations
- For law enforcement
- If required by law
- For public health activities such as tracking diseases
- To protect victims of abuse, neglect, or domestic violence
- For health oversight activities such as fraud investigations
- To Workers' Compensation if you are injured at work
- For certain judicial or administrative proceedings
- To coroners, medical examiners and funeral directors
- For government functions such as national security and intelligence
- To a correctional institution if you are an inmate
- To avert serious threat to public health or safety

We may also use your information without your permission to: recommend treatment alternatives; tell you about health benefits and/or services; send, text, email or call you with appointment reminders; ask you to make a charitable gift; to communicate with those involved in your care.

Except as otherwise permitted by law, all other uses and disclosures not described above will require your signed authorization. You may revoke any authorization you provide at any time by delivering a written statement directly to the Privacy Officer (listed below), except to the extent that I have already taken action in reliance on your authorization.

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Please know that federal and state law requires special privacy protections for certain highly confidential information about you, including but not limited to: Psychotherapy notes, Mental health and developmental disabilities services, Alcohol and drug abuse prevention, treatment and referral, HIV / AIDS testing, diagnosis or treatment, Venereal disease(s), Genetic testing, Child abuse and neglect, Domestic abuse of an adult with a disability, Sexual assault.

In order for us to disclose your highly confidential information for a purpose other than those permitted by law, I must obtain your written authorization.

Jennifer Richards Little is a hybrid entity. Our Physical Therapy operations are covered functions, while all of our other services are not covered functions.

YOUR RIGHT: Under HIPAA, you have the right to request in writing:

- Restrictions on how I use or disclose your medical information
- Confidential communications to an alternate phone or address other than your home
- Access to your medical information to review and obtain a copy, subject to federal and state laws (fees may apply)
- An amendment to your medical information if you feel you or your healthcare provider needs to make additions or corrections
- An accounting of disclosures of your medical information for purposes other than treatment, payment, health care operations or made pursuant to an authorization
- A paper copy of this Notice even if you have received it electronically
- A revocation of any specific authorization obtained in connection with your privacy, such as for marketing and research

While I will consider all requests for privacy restrictions carefully, I am not required to agree to any requested restrictions.

MY RESPONSIBILITIES: I am required by law to maintain the privacy of your medical information, to provide you with this written Notice of Privacy Rights and Practices if requested, and to abide by the terms of the Notice currently in effect. I reserve the right to change this Notice and our privacy practices and make the new provisions effective for all information we maintain. Revised Notices will be posted in our offices, and will be available from your direct treatment provider.

FOR MORE INFORMATION: If you would like further information about your privacy rights, are concerned that I have violated your privacy rights or disagree with a decision that I made about access to your Protected Health Information, you may contact our Privacy Officer at the address or phone number below. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. I will not retaliate against you if you file a complaint with the Director or us.
Jennifer Richards Little and its employees are committed to protecting patient privacy.

By voluntarily signing below, I show that I have read, or have had read to me, the above Notice of Privacy Rights and Practices. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE (Or Patient Representative – indicate relationship if signing for patient)
Date: Signature:

PRACTITIONER SIGNATURE
Date: Signature:

APPOINTMENT CANCELLATION POLICY

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I require 24 hours' notice for any cancellations, otherwise you will be responsible for paying your usual treatment fee. Appointments may be canceled by calling or texting (508) 932-3086 or emailing jen@jenniferrichardslittle.com.

APPOINTMENT NO-SHOW POLICY

When you set an appointment, I set aside time in the schedule just for you, so I can be certain to provide you the care you need. I value your time and know you value mine. If you cannot come to your appointment and haven't canceled, you will be charged a regular appointment fee. If you are using a promotional gift certificate, I will redeem your gift certificate as being used.

APPOINTMENT VIRUS POLICY

I am committed to minimizing the risk from all viruses, including COVID-19.

I employ universal precautions including but not limited to:

- hand washing before and after each client treatment
- wiping down treatment surfaces, door knobs, and bathroom fixtures with a disinfectant after each client use
- changing table linens in between each client
- spacing out appointments to avoid client overlap in a waiting room
- wearing gloves for all mouthwork or wound inspections/ treatments or if I have any open wounds on my hands
- wearing a mask for every session
- cancelling your appointment if I have a fever
- require my clients to wear a mask except for during mouthwork techniques

I expect YOU to cancel your appointment if:

- You are feeling sick for any viral reason.
- You are experiencing any symptoms of COVID-19.
- You have been in close contact with someone who is suspected to have, or was diagnosed with, COVID-19.
- You recently traveled to an area deemed high risk.
- You are a high-risk individual.

In your appointment reminder, you will receive this screening questionnaire:

If the answer to any is yes, please reschedule your appointment.
Are you experiencing any of the following symptoms:

- Cough
- Shortness of breath/difficulty breathing
- Fever (please take your temperature.
- Chills
- Muscle pain
- Repeated shaking with chills
- Headache
- Sore throat
- New loss of taste or smell
- Sinus pain

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- Fatigue

Have you been exposed to anyone with any of the above symptoms in the past 14 days?
Is anyone in your immediate household suffering from suspected or confirmed COVID-19?

If the answer to any of the screening questions is yes, please reschedule your appointment by calling or texting 508-932-3086 or emailing jen@jenniferrichardslittle.com.
There will be no cancellation fee for virus cancellations within 24 hours of your appointment.

By voluntarily signing below, I show that I have read, or have had read to me, the above Appointment Cancellation, No-Show, and Virus Policies. I agree to the policies and agree to make payment for missed appointments. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE (Or Patient Representative – indicate relationship if signing for patient)
Date

PRACTITIONER SIGNATURE Date