Client Service Agreement and Informed Consent

This Client Service Agreement (“Agreement”) is between Seniority Wellness & Consulting, LLC, an Ohio and limited liability company , (“we” or “us”) and our clients (“you” or “the client”) Term. The term of this Agreement will run from the date it is signed by both parties on an as needed basis until terminated by either party, or provided here under Services: We will provide skilled therapy services as per the below terms and a service plan which shall be developed in consultation with you and your designated representative or family member. Rehabilitation therapy involves several methods of evaluation and treatment. We may use a variety of procedures and treatments to help you reduce your pain, improve your strength, range of motion, mobility, and activities of daily living. And where applicable for speech therapy services, treatments are for the purpose of addressing cognitive communication disorders, voice, language and/or swallowing impairments. As with all forms of medical treatment, there are benefits and risks involved. Client responses to a specific form of treatment can vary widely from client to client and it is not always possible to predict responses to a given form of treatment. There is a risk that your treatment may result in pain, injury, or aggravation of a previous condition. This consent form is based upon your informed decision to participate in the proposed treatment plan and therapy services. You have the right to inquire as to the form of treatment based upon your history, diagnosis(s) and symptoms. You may discuss with your provider the potential risks and benefits of a specific treatment and possible alternative treatment. You have the right to decline treatment at any time or during your treatment sessions. Services may be provided in your home, or in a mutually agreed upon alternate designated location (i.e fitness facility, family member’s home, work-space). We may reject any alternate location proposed in our sole discretion.

Fees and Billing: Maximum out of pocket fees are set forth as follows and are per session

$225 Evaluation with Treatment/ Consultation; $160 Follow up visits

-Deductible met:-_____ Deductible Not Met: _____

-After Deductible has been met coinsurance _____% which is an estimate of $____per session

-After Deductible has been met copay $_____

Session lengths may vary between 75-90minutes for initial Evaluation; 45-70 minutes for follow up visits. Session times are determined based on our discretion and our professional judgement. All individual sessions are billed on the day of service to the client or third party payor (if applicable). If the client has a financial obligation to cover services in combination with their insurance benefit they will receive a statement. We

ask that statement balances be addressed within 2 weeks of being issued a statement. Failure to pay on your statement balance within the month of it being issued may result in discontinuation of services. Forms of acceptable payment include Cash, Check (made out to Seniority Wellness & Consulting) or Credit Card (via Ivy Pay App). We will assess a $25 fee for all returned checks.

Initial_____

Payment disclaimer: I authorize Seniority Wellness & Consulting LLC and its representatives to share records and information (by telephone, email/fax, or in writing, including reports of diagnosis, treatment and prognosis, recommendations, benefits payable, as well as any other data pertinent to my treatment, by Seniority Wellness & Consulting LLC) with third parties participating in my therapy including any party through which an insurance program is paying for all or part of my therapy (if applicable) and my physician. I authorize payment to be made directly to Seniority Wellness & Consulting LLC. I understand that I am responsible for any copay, deductible and services not covered by a third party payor. I understand that it is my responsibility to notify Seniority Wellness & Consulting of any changes to my form of payment (i.e insurance ID and/or change in eligibility of benefits).

Initial_____

We are a mobile outpatient therapy provider and will provide the majority of services in your home. If at any time your physician orders a home health agency to service you for therapy or nursing in your home and they initiate care please notify us immediately. Medicare guidelines indicate that a beneficiary cannot be covered for Medicare A (covering the home health agency's services) and Medicare B (outpatient services) services at the same time. We ask that you also notify us if you are seeing another therapy provider of the same discipline through a different therapy business. Failure to notify us of this change will result in the client being assessed for all charges due to a conflict with third party payor reimbursement. This change may also result in an immediate discontinuation of our services.

Initial_____

Seniority Wellness & Consulting LLC and its associates prides themselves on being on time and always available for patient appointments, however there may be instances where your therapist is sick or unable to keep your appointment. If there is a scheduling conflict for the therapist, you will be contacted as soon as possible via text, call, and/or email (per patient preference) to reschedule your appointment. If your appointment must be canceled or rescheduled due to a staff member conflict, you will not be charged a fee and we will reschedule your appointment to the soonest possible date and time.

Should you need to cancel your appointment please extend a courtesy call to 513-799-8263 to notify your therapist the day prior to your scheduled appointment. Cancellations after 9am the day of the appt will result in a $75 cancellation fee. A total of 3 cancelled therapy sessions within an episode of care will result in discontinuation of services.

Initial____

Confidentiality: Professional and personal ethics require us to keep your medical information confidential. We will not discuss such information with anyone without your permission, except as allowed by those rules or as required by law, provided that you expressly agree that we may release any such information to (a) individuals acting in official capacities as your representative or agent, (b) anyone you designate as being entitled to such information or (c) other health care providers involved in your care. Please initial that you have been given an opportunity to read the "**Notice of Privacy Practice"**

Initial_____

Governing Law. The laws of the state of Ohio shall govern this agreement. Consent for treatment. By signing below, I authorize Seniority Wellness & Consulting, LLC to provide treatment to myself for what is considered medically necessary for my physical condition. I understand that I am agreeing to those services for which the therapist (issuing me this form and additional associates where applicable is qualified to provide within the scope of the provider's license, certification and training, and under the terms set forth in the Client Service Agreement.

This current injury is considered either of the following; Please check line that applies

___New Injury/Issue/Diagnosis __ Exacerbation of a previous Injury/Issue/Diagnosis

___Related to Prior Workman's Comp Injury- Claim ___Related to a personal Injury- MVA claim

I certify that I have read this form (or have had it read to me) and fully understand the above consent. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

PT SOC_____ OT SOC_____ ST SOC____

Name (please print)_____

Signature (client; client representative)_____ Date:_____

Witness Signature:_____

Seniority Wellness & Consulting LLC

ph: 513-799-8263 fax: 513-912-0993 email- info@senioritywc.com

Consent for Communication preferences outside of Therapy Session

I wish to be contacted in the following manner: *(Circle all that apply)*

Home phone#: _____ Cell phone #_____

Email _____

Ok to leave message with detailed information,

Ok to leave message with call back number only

Ok to communicate via text message

Ok to communicate via email

Patient (Patient representative) Signature:

Proposed Therapy Plan

I understand that my therapist has recommended my therapy be for ____x/week for ____weeks. After this I will either be discharged or re-assessed to determine the need for additional sessions. This can vary based on my progress and goals met.

My Therapy goals consist of

1.

2.

3.

4.

5.

6.

7.

8.