Frankly Pelvic LLC
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Pelvic Consent Form

Client/Patient Name: _____
Date of Birth: _____

Pelvic Examination Consent:
Florida legislature requires a written consent for any person(s) undergoing a pelvic examination regardless of age or gender.
I, the above listed Patient or legally authorized person for the Patient, hereby acknowledge, understand, and consent to receive and participate in pelvic examinations and treatments performed by my licensed pelvic health physical therapist, Dr. Kelly Frank PT, DPT, when deemed clinically necessary.
For the purpose of this consent form, a pelvic examination can include external palpation to bony and soft tissue structures as well as a possible internal (vaginal and/or rectal) examination based on your symptoms.

I understand I have the right to give/revoke this authorization at any time during the session or my evaluation and/or treatments. Verbal consent will continue to be obtained and received throughout all treatments and during each session as I am and will continue to be in full control of my body and given options for all treatment interventions.

I understand I have the option to provide my own chaperone or support person to each session which can include a family member, friend, or other support person of the patient(s) selection.

Patient name: _____
Patient signature: _____ Date: _____

Informed Consent for Physical Therapy Treatments

Informed consent means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. Given each individual's presenting condition there is a variety of physical therapy services and interventions that may be included in your care and will be explained to you by your physical therapy during the initial evaluation and subsequent treatment sessions.

Every individual responds differently to physical therapy interventions, and it is therefore difficult to predict your response(s) to any one treatment technique or procedure. Frankly Pelvic cannot guarantee that treatment will resolve or improve your condition or guarantee that you will not have a negative reaction to treatment. Prior to your consent to treatment, your physical therapist will discuss their opinion on the potential results and anticipated outcomes given the various treatment techniques and procedures to be provided.

Potential benefits include but are not limited to: Decrease in pain and symptoms, improvement in function, strength, flexibility, endurance, awareness, and greater knowledge and ability to manage presenting condition(s).

Potential risks may include: Increase or aggravation of pain or presenting symptoms, and may cause injury. Most aggravation or increased pain is temporary can be discussed with your physical therapist. I agree to contact my medical provider, primary care physician and/or physical therapist if symptoms do not decrease in 1-3 days.

You have the right to decline any part of treatment at any time for any reason. It is your right to ask your physical therapist questions regarding any part of your care and to discuss the potential risks and benefits specific to your treatment plan. It is your right to decline participating in the physical therapy program presented. Alternatives to physical therapy can be discussed including return to your physician for other treatment options.

I have read and understand all of the information above and consent to physical therapy evaluation and treatment. I agree to fully cooperate, participate, and comply with the established plan of care.

Patient name:

Patient signature: _____ Date: _____

Notice of Privacy Practices:

TO OUR PATIENTS, THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A CLIENT OF FRANKLY PELVIC) MAY BE USED & DISCLOSED, & HOW YOU CAN OBTAIN ACCESS TO YOUR HEALTH INFORMATION. THIS IS REQUIRED BY THE PRIVACY REGULATION CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA). FRANKLY PELVIC IS DEDICATED TO MAINTAINING THE PRIVACY OF YOUR HEALTH INFORMATION. WE ARE REQUIRED BY LAW TO MAINTAIN THE CONFIDENTIALITY OF YOUR HEALTH INFORMATION. WE REALIZE THAT THESE LAWS ARE COMPLICATED, BUT WE MUST PROVIDE YOU WITH THE FOLLOWING IMPORTANT INFORMATION:

THE FOLLOWING CIRCUMSTANCES MAY REQUIRE US TO USE OR DISCLOSE YOUR HEALTH INFORMATION:

1. TO PUBLIC HEALTH AUTHORITIES & HEALTH OVERSIGHT AGENCIES THAT ARE AUTHORIZED BY LAW TO COLLECT INFORMATION.
2. LAWSUITS AND SIMILAR PROCEEDINGS IN RESPONSE TO A COURT OR ADMINISTRATIVE ORDER
3. IF REQUIRED TO DO SO BY A LAW ENFORCEMENT OFFICIAL
4. WHEN NECESSARY TO REDUCE OR PREVENT A SERIOUS THREAT TO THE HEALTH & SAFETY OF ANOTHER INDIVIDUAL OR THE PUBLIC. THESE DISCLOSURES WILL ONLY BE MADE WITH PERSONS OR ORGANIZATIONS WHO ARE ABLE TO HELP PREVENT SUCH A THREAT.
5. IF YOU ARE A MEMBER OF THE U.S. OR FOREIGN MILITARY (INCLUDING VETERANS) AND IF REQUIRED BY THE APPROPRIATE AUTHORITIES.
6. TO FEDERAL OFFICIALS FOR INTELLIGENCE AND NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW.
7. TO CORRECTIONAL INSTITUTIONS OR LAW ENFORCEMENT OFFICIALS IF YOU ARE AN INMATE/UNDER THE CUSTODY OF A LAW ENFORCEMENT OFFICIAL.
8. FOR WORKERS COMPENSATION AND SIMILAR PROGRAMS.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. COMMUNICATIONS: YOU CAN REQUEST THAT FRANKLY PELVIC COMMUNICATE WITH YOU ABOUT YOUR HEALTH AND RELATED ISSUES IN A PARTICULAR MANNER OR AT A CERTAIN LOCATION. FOR INSTANCE YOU MAY ASK THAT WE CONTACT YOU AT HOME RATHER THAN WORK. WE WILL ACCOMMODATE ALL REASONABLE REQUESTS.
2. YOU CAN REQUEST A RESTRICTION IN OUR USE OF DISCLOSURE OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. ADDITIONALLY, YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT DISCLOSURE OF YOUR HEALTH INFORMATION TO ONLY CERTAIN INDIVIDUALS INVOLVED IN YOUR CARE OR THE PAYMENT FOR YOUR CARE, SUCH AS FAMILY MEMBERS OR FRIENDS.
3. YOU HAVE THE RIGHT TO INSPECT AND OBTAIN A COPY OF THE HEALTH INFORMATION THAT MAY BE USED TO MAKE DECISIONS ABOUT YOU, INCLUDING PATIENT AND MEDICAL RECORDS.

4. YOU MAY ASK US TO AMEND YOUR HEALTH INFORMATION IF YOU BELIEVE IF IS INCORRECT OR INCOMPLETE AS LONG AS THE INFORMATION IS KEPT BY AND FOR OUR PRACTICE.

5. RIGHT TO A COPY OF THIS NOTICE. YOU ARE ENTITLED TO RECEIVE A COPY OF THIS NOTICE OF PRIVACY POLICIES. YOU MAY ASK US TO GIVE YOU A COPY OF THIS NOTICE AT ANY TIME. TO OBTAIN A COPY OF THIS NOTICE, CONTACT OUR OFFICE.

5. RIGHT TO FILE A COMPLAINT. IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH OUR PRACTICE OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

7. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES. FRANKLY PELVIC WILL OBTAIN YOUR WRITTEN AUTHORIZATION FOR USES AND DISCLOSURES THAT ARE NOT IDENTIFIED BY THIS NOTICE OR PERMITTED BY APPLICABLE LAW. IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OR OUR HEALTH INFORMATION PRIVACY POLICIES PLEASE CONTACT FRANKLY PELVIC.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF THE HEALTH INFORMATION PRIVACY ACT.

PATIENT NAME: _____
PATIENT SIGNATURE: _____ DATE: _____

PRACTICE POLICIES:

FINANCIAL POLICY: I understand and agree, regardless of my insurance status, that I am solely responsible for the payment of all services at time of service provided to me by Frankly Pelvic LLC.

CANCELLATION POLICY: We understand that life gets busy and has unexpected twists, but we ask that you please respect our time as well as other patients in need of therapy. In order to best serve our patients, you will be allowed one (1) emergency last-minute cancellation. After that, Frankly Pelvic cancellation policy will be strictly enforced.
Frankly Pelvic Cancellation Policy: We must be notified at least 24 hours prior to your scheduled appointment time **or you will be responsible for a $60 cancellation fee**.
I certify that I have read this document in its entirety, understand and agree to the terms and conditions within.

Patient name: _____
Patient signature: _____ Date: _____

Please fill out and send your signed PDF to Dr Frank at:
drkelly.frank@franklypelvic.com