INFORMED CONSENT
GroundswellMFR, LLC

I, _____ (hereafter "Patient"), have retained the services of GroundswellMFR, LLC, a Tennessee limited liability company (hereinafter "Provider") to provide me with occupational therapy services.

RECITALS

WHEREAS, Provider owns and operates an occupational therapy center with services provided both remotely and at provider's center located at 922 Harpeth Valley Pl, STE 2, Nashville, TN 37221

WHEREAS, Provider has fully explained, and Patient fully understands the examination and treatment procedures involved in occupational therapy, including but not limited to the risks, benefits, and alternatives available to Patient. Provider will only perform occupational therapy treatment within Provider's scope of practice and all procedures will be thoroughly discussed and consented to by Patient prior to its application.

WHEREAS, Provider has explained in full to Patient, and Patient understands the nature of occupational therapy to involve physical contact with the body which includes palpation (manual examination) of body part(s), manual treatment (direct contact with skin) of body part(s), and close observation of body part(s). To facilitate treatment Patient further understands treatment may require the removal of some clothing articles.

WHEREAS, Provider has explained to Patient, and Patient fully understands their financial obligation to Provider for services provided for examination and treatment sessions. Further, Patient understands and accepts responsibility to make full payment at the end of each session.

WHEREAS, Provider requires the consent of the parent or legal guardian of a Patient that is a minor, under eighteen (18) years of age. By consenting to the services of Provider, the parent or legal guardian of a minor accepts full financial responsibility for all treatment provided to the minor, whether or not the parent or legal guardian is present at the time of the examination or treatment session.

WHEREAS, Patient shall retain the right to cease and refuse the services of Provider at any time during examination and treatment. It is understood by Patient, the right to cease and refuse the services of Provider shall not excuse Patient's financial obligation for services provided to Patient by Provider, including but not limited to those services not fully completed at the request of the Patient.

WHEREAS, Provider has made no assurances or guarantees to Patient with regard to the results and/or outcomes of the occupational therapy to be provided and/or provided to Patient. Patient understands that their participation is purely voluntary.

WHEREAS, Patient has fully disclosed to Provider all existing medical conditions known to Patient at the time of initial examination and treatment and has completed a medical history form to the best of their knowledge. Patient shall have the sole responsibility to communicate and update Provider of any changes to Patient's medical conditions which may or may not affect treatment outcomes.

WHEREAS, Patient consents to the use of photography and/or video during treatments for the purpose of the Patient's care. These will be used only as necessary for postural comparison, awareness and education during evaluation, treatment, assessment and reevaluation. Patient will be made aware at any point during treatment that photos and/or videos are being taken. Photos and/or videos are part of the Patient's medical record and cannot be reproduced or used without Patient's consent.

WHEREAS, Patient understands that they have certain rights to privacy regarding their protected health information. These rights are given to them under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In compliance with HIPAA, Patient has received a copy of the GroundswellMFR, LLC Notice of Privacy Practices which describes in detail how Provider may use or disclose the protected health information of Patient. Patient, by their signature, ascertains they have been provided and reviewed Provider's Notice of Privacy Practices before signing this informed consent. Patient understands by signing this informed consent they are authorizing Provider to use and disclose their protected health information, in compliance with HIPAA regulations, to for the purposes of:

- Treatment (including direct or indirect communication with other healthcare providers involved in Patient's care)
- Payment (i.e. insurance providers, third party payers)
- Healthcare operations

Patient further understands that Provider reserves the right to change the privacy practices as allowed by law. In the event of a change to Provider's privacy practices, Patient will be notified at their next visit to update their signature and consent. Patient has the right to revoke this consent in writing at any time.

WHEREAS, Patient acknowledges that all questions and concerns have been addressed by Provider and answered to Patient's satisfaction prior to signing this Informed Consent form.

NOW, THEREFORE, Patient has read and certifies their understanding of the contents of this informed consent form as of this date and by their signature freely consent to Providers occupational therapy services.

DATED: _____ day of _____, 2025

_____
Signature of Patient

_____
Signature of Parent / Legal Guardian (if applicable)