Alliance
Physical Therapy Partners

Student Clinical and Internship Agreement

IF ACCEPTED AS A CLINICAL STUDENT, I AGREE THAT:

1. My services are donated to Alliance Physical Therapy Group without contemplation of compensation or future employment, and I will not be covered by Alliance Physical Therapy Group ("Alliance") for workers compensation or unemployment as a result of my services.

2. I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions on Alliance premises. In addition, I shall not solicit business for attorneys, insurance companies or act as an agent for an attorney in the solicitation of business. I shall report all known occurrences or solicitations to the Corporate Compliance Officer.

3. I shall submit to examinations, which may include chest X-rays, TB test, appropriate laboratory tests and / or immunizations that may be necessary or part of my observation time. I hereby authorize my doctor(s) to furnish Alliance information concerning my health. I also authorize the person(s) making the examinations to report the results to Alliance.

4. I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional, in quality consistent with the standards set by Alliance.

5. I shall attempt to resolve any problems or concerns related to my observational activities with the site manager, and/or Operations and HR Supervisor.

7. I shall at all times uphold the philosophy, standards and policies of Alliance.

8. I understand that Alliance reserves the right to terminate my clinical internship status as a result of: (a) failure to comply with Alliance policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory behavior, or work appearance; (d) any other circumstances which, in the judgment of Alliance and / or department liaison, would make my continued service as a volunteer contrary to the best interests of Alliance.

I have read each of the above conditions and I agree to be bound by them.

Signature: _____ Date: _____

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Confidentiality and Privacy of Patient Information

Alliance Physical Therapy Group ("Alliance") policy and federal regulations protect the privacy of our patients' health information. The Health Insurance Portability and Accountability Act (HIPAA) is a set of federal rules that defines what information is protected, sets limits on how that information may be used or shared, and provides patients with certain rights regarding their information. Alliance has its own policies that reflect these regulations as well as best ethical standards.

These rules protect information that is collected or maintained, (verbally, in paper, or electronic format) that can be linked back to an individual patient and is related to his or her health, the provision of health care services, or the payment for health care services. This includes, but is not limited to, clinical information, billing and financial information, and demographic/scheduling information. Even the fact that an individual has received care at Alliance is protected by Alliance policy and federal regulations.

As a visitor at Alliance you are required to conduct yourself in strict conformance to all applicable laws and Alliance policies governing confidential information. Simply by being in the Alliance clinic, you may encounter confidential patient information. Patient care is often coordinated in semi-public environments where there is the risk that patient information may be heard or viewed by individuals not directly involved in the patient's care. Alliance has polices intended to limit the risks of such incidental disclosures of patient information.

Any patient information you see or hear, either incidentally or by observing, must be kept confidential. By signing below, you are agreeing to abide by Alliance policies regarding confidentiality of patient health information.

As a condition of and in consideration of, my use, access, and/or disclosure of confidential information, I, understand and agree to the following:

- I will access, use, and disclose confidential information only as permitted by Alliance. This means that I will only access, use, and disclose confidential information that I have been given authorization to access, use, and disclose.

- I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions will result in the termination of my privilege to observe and participate in rounds in clinical areas and I may be subject to legal liability as well.

- My signature below indicates that I have read, accept, and agree to abide by all of the terms and conditions of this Agreement and agree to be bound by it.

I have read each of the above conditions and I agree to be bound by them.

Signature: _____ Date: _____

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Waiver and Release of Liability

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of Alliance Physical Therapy Group ("Alliance"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the observation at Alliance unless such injury of loss arises solely out of Alliance's willful misconduct.

I am personally liable for all injury, illnesses or damages to myself or others related to my participation in this event. I hereby release, hold harmless, acquit and forever discharge Alliance its agents, employees, officers, affiliates and subsidiaries for any and all actions, cause of action, claims, demands, damages, costs, expenses any present or future charges arising out of, or related in any way to my observation in patient care areas at Alliance or its associated entities.

I acknowledge that I have read and fully understand this Waiver and Release of Liability.

Signature: _____ Date: _____

Print Name: _____