

PHYSICAL THERAPY 180

Thank you for choosing Physical Therapy 180 for your physical therapy, acupuncture or massage needs. Please read the below information and sign or initial where indicated.

Contact Information:

I authorize contact from this office to confirm appointment, treatment, & billing via:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ email confirmation ☐ Any listed

I authorize information about my health be conveyed via:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ email confirmation ☐ Any listed

Communication of Health Information

Please List any other parties who can have access to your health information

(This includes step parents, grandparents and any care takers/ representative that can have access to this patient's record)

Name: _____

Name: _____

Initials _____ Consent of Treatment: I consent to rehabilitation and related services at Physical Therapy 180. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services are considered necessary and within guidelines established by myself and treating physical therapist, acupuncturist or massage therapist.

Initials _____ Assignment of insurance benefit/ payments: I authorize payments be made on my behalf for physical therapy/ acupuncture/ massage services furnished to me, to be made directly to Physical Therapy 180.

Initials _____ Agreement to inform of changes in demographics/ insurance: I agree to inform Physical Therapy 180 immediately of any changes to my personal information (such as address, phone etc) and insurance (primary, secondary, other). I understand that failure to immediately disclose this change could result in treatment being unpaid/ preauthorization if applicable and I will be responsible for payment in full.

Initials _____ Agreement to notify: I agree to provide 24 hour advance notice of appointment changes or cancellation. If 24 hour notice is not provided I will be responsible for a **\$35.00 fee** payable in full prior to my next appointment. For the convenience of our patients a voice mail message may be left on the telephone before/ after regular business hours.

Initials _____ Non covered services: I understand that services/ supplies may not be covered by all insurance. Some insurance have certain restrictions/ limitations (i.e.: preauthorization, visit/ dollar limits, not deemed medically necessary, maintenance). I agree to be financially responsible for any and all charges not covered by insurance.

Initials _____ Authorization: I authorize Physical Therapy 180 to use PHI for the purpose of treatment, payment and health care operations.

Patient Acknowledgment of Receipt of Privacy Practices

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for our physical therapy offices. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment or information be sent to other attending Doctor/ Facilities in the future.

Please **print** your name

Please **sign** your name

Legal Representative

Description of Authority