Physical Therapy Associates

PATIENT CONSENT FORM

I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist. The patient is responsible for charges incurred, regardless of insurance coverage. If we have a contract with your insurance carrier, we will file the claim for your services. If the insurance company denies payment for no referral, non-covered services, deductible, etc., I am responsible for all balances due.

PHYSICAL THERAPY ASSOCIATES, P.S. will extend the courtesy of a credit account. Unless other arrangements are made with the billing department, payment is expected within 30 days of billing.
Physical Therapy Associates, P. S. accepts assignment for Medicare patients.

I understand, in some instances, the applicable physical therapy charges billed to my insurance company may not be covered under my insurance policy. I agree to be responsible for any portion of my bill not covered by insurance. I UNDERSTAND IT IS MY RESPONSIBILTY FOR CHECKING ON MY INSURENACE BENEFITS AND COMPLYING WITH THE REQUIREMENTS OF THE POLICY.

I have completed the front page truthfully, ready and understand the above statements.

_____ _____
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) DATE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Physical Therapy Associates has the right to change its Notice of Privacy Practices from time to time and that I may contact Physical Therapy Associates at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____
PATIENT NAME DATE

_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN