Integrated Physical Therapy Services, Inc.

PATIENT CONSENT, AGREEMENT, & AUTHORIZATION FOR TREATMENT

Release of Information and Consent for Treatment:

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment at Integrated Physical Therapy Services, Inc. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care. I give permission to Integrated Physical Therapy Services, Inc. to release information, verbal and written, contained in my medical record and other related information to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment. I authorize Integrated Physical Therapy Services, Inc. to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Assignment of Benefits

I authorize payment directly to Integrated Physical Therapy Services, Inc. for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Integrated Physical Therapy Services, Inc. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Documentation of Good Faith to Obtain Written Acknowledgement

I made **good faith effort to obtain the patient's written acknowledgement** of our Notice of Privacy Practices or protected health information by: [x] showing the patient the Notice of Privacy Practices posted in our office to read prior to receiving treatment.

Authorization for Phone Contact

I hereby authorize the staff of Integrated Physical Therapy Services, Inc. to leave information on my phone answering machine-voicemail regarding insurance information, confirmation of appointments, and contacts regarding further scheduling. I also authorize Integrated Physical Therapy Services, Inc. to leave the aforementioned information with a family member.

Non –Discrimination

Integrated Physical Therapy Services, Inc. and the patient agree that services are given without regard to race, color, sex, age, national origin, or handicap.

Cancellation of Scheduled Physical Therapy Visits:

Most local Physical Therapy centers charge a no-show fee for individuals who do not meet scheduled appointments (no-shows). At Integrated Physical Therapy Services, Inc., we fully expect all our patients and members to abide by the common courtesy of a phone call if a scheduled visit needs to be changed. Chronic no-shows will be discharged from our program.

Payment Guarantee

I agree to pay Integrated Physical Therapy Services, Inc. for the services provided to me or the party named above. If any law, such as workers' compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The agreement form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Integrated Physical Therapy Services, Inc.

Patient or Guardian Signature: _____ Date: _____

The signature above certifies that I have read, understand, and agree with the above information (all categories).

POA / Guardian Notification ***FOR OFFICE USE ONLY***

On _____ at am / pm, I spoke with _____, POA, and received consent for PT / OT for the above patient. I discussed insurance, details of care, and HIPAA. Consent to evaluate, bill and treat was verbally approved by _____, POA

Therapist Signature: Date: