Date: ___/___/_____

PATIENT CONSENT FORM

For therapy services through Orthopedic & Sports Physical Therapy Inc.

Please Print

Patient Name: _____ Date of Birth: _____/_____/_____
First MI Last

SSN _____-_____-_____ Home Phone #: _____

Mailing Address_____ Cell Phone #: _____

_____ Work Phone #: _____
City State Zip Code

☐check if above is billing address Email Address: _____

_____ Is it okay to email and/or text appointment reminders? ☐e-mail only ☐text only

Emergency Contact(s): _____/_____ Phone #: _____
(If minor – list parent(s)/guardian(s)) **Name & Relationship**

Cell #: _____

Can we discuss your condition with your emergency contact: _____ Yes _____ No

Referring Physician and/or Primary Physician: _____

Insurance Policy Holder/Billing Address (if different from above):

Name: _____ Date of Birth: _____

_____
Address City State Zip Code

Policy Holder's Phone #: _____

Please read and provide consent:

1. I, the patient above, (or _____for the patient), do hereby voluntarily consent to medical treatment deemed as appropriate by the physical therapist, occupational therapist, and/or speech therapist; and/or the assistants of the previously named therapists, as ordered by myself and/or the above physician, their assistants, consultants, and is necessary in his/her professional judgment.
2. I authorize payment directly to Orthopedic & Sports Physical Therapy Inc. of the benefits otherwise payable to me but not to exceed the regular charges for this period of treatment. If I have sought litigation due to my injury and refuse to provide the appropriate insurance information, I understand that I am required to pay Orthopedic & Sports Physical Therapy Inc. at the time services are provided. I also understand that if I have filed a workers compensation claim and my claim is denied, I will then be responsible for payment of services as they are received if I do not provide health insurance. I understand that I am financially responsible to Orthopedic & Sports Physical Therapy Inc. for charges not covered by my insurance.
3. I hereby authorize Orthopedic & Sports Physical Therapy Inc., its employees or agents, to release medical information regarding myself and my current condition to my insurance company for purpose of payment and/or quality reviews; and referring, consulting, treating physicians, or other medical providers as necessary to support continuity of care. This authorization will remain valid until revoked in writing.
4. I authorize the use of my records for physical therapy & office quality assessments to help provide quality care. Research results do not identify individuals by name or any other personally identifying characteristics. This authorization does not expire but may be revoked or limited in writing by me at any time.

Turn Over to Complete

5. If appropriate I consent to the use of still photography and/or video analysis as a component of my physical therapy evaluation at Orthopedic & Sports Physical Therapy Inc. I understand that the photographs or videotape are part of medical record and cannot be reproduced or used in any other manner, without my written consent.
6. I understand that I am responsible for checking with my insurance company regarding any co-pays, deductibles or provider information that pertain to my treatment at Orthopedic & Sports Physical Therapy Inc. Physical Therapy services are billed as free standing clinic setting.
7. I understand that during the course of therapy, I may also be seeing a therapist assistant.

Insurance Benefits *(Please Read Carefully)***:**
Your insurance is a contract between you and your insurance company.
Because of privacy laws, we are unable to obtain details of your specific coverage including deductibles, co-pays, co-insurance, your financial responsibilities and pre-authorization requirements. Only you can obtain this type of information by either calling the customer service number on the back of your insurance care or by checking with your employer's benefits department.

Your health care provider, insurer, or plan may require a physician referral or prior authorization and you may be obligated for partial or full payment for any therapy services rendered.

It is critical that you check to determine if there are any pre-authorization requirements before completing therapy. Please contact the front desk if we have any responsibility in this process. We will be glad to follow through with any requirements. By double-checking on this, maximum benefits will be paid by your insurance, which will reduce your financial responsibility.

Please initial:

_____ **I understand that I am responsible for canceling any appointments 24 hours ahead of time; otherwise there is a $30 charge. If I do not show up for 2 consecutive appointments without calling, then future existing appointments will be cancelled. The Cancellation/No Show Policy is attached for your information.**

_____ **Please initial that you have received the HIPAA information (Notice of Privacy Practices) that is attached for your record. The notice describes how medical information about you may be used. Please review it carefully.**

Due to HIPAA and confidentially, please read and check the following as appropriate.

_____ I agree to the release of my medical or other information in order to process my insurance claims.

____ I am a self-pay patient, and I choose **not** to share any information with my insurance provider.

_____ It is okay to speak with or leave messages regarding your appointments with anyone at your home, including on your answering machine.

_____ It is okay to speak with or leave messages regarding your appointments with anyone at your work.

Is there anyone that you do not want us to leave a message with regarding appointments? Yes No
If Yes, list names: _____

I have read this form and certify that I understand its contents as of this date and time. I agree that this form is valid for up to 1 (one) year from the signed date.

_____
Signature of Patient Date

_____
Guardian or Witness of minor Date