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, health & billing via:
☐ Cell Phone ☐ Home Phone ☐ Text/email ☐ Work Phone ☐ Any listed

Communication of Health Information
Please List any other parties who can have access to your health information
(This includes spouse, step parents, grandparents, family member, care takers/representative, health care providers that can have access to this patient's information)

Name:_____ Name:_____

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.

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.

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.

Agreement to notify: I agree to provide 24 hour advance notice of appointment changes or cancellations. If 24 hour notice is not provided I will be responsible for a **$35.00 fee** for the first visit, the next visit will be charged as a full appointment and all fees will be payable in full ***PRIOR*** to your next appointment. All future appointments will be removed from the schedule and your name will be placed on a standby list allowing you to call the day you are able to attend and the staff will check availability. This also applies to no-show appointments. For the convenience of our patients a voice mail message may be left on the telephone before/after regular business hours.

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. ***As a COURTESY***, Physical Therapy 180 will verify eligibility and benefits with your insurance company; however, this is ***NOT*** a guarantee of benefits or payment. We strongly encourage all patients to check the benefits with their insurance company.

Interest Charge: I acknowledge my account will be charged 1.5% interest (18% annually) on any unpaid balance.

Authorization: I authorize Physical Therapy 180 to use PHI (protected health information) for the purpose of treatment, payment and health care operations.

Patient Acknowledgment of Receipt of Privacy Practices and current office policies:
The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices and office policies listed above 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.

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Please ***print*** your name Date Please ***sign*** your name

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Legal Representative Date Description of Authority