Physical Therapy Patient Agreement

Thank you for choosing Family Physical Therapy and Wellness, LLC for your rehabilitation needs. Please read, initial each section, and sign the following agreement as it lays out our billing, scheduling and cancellation policies. If you have any questions, please ask for clarification.

Consent for Treatment: I have a condition requiring physical therapy intervention, and consent to the delivery of such care. In order to improve my physical condition in regards to pain, range of motion, strength or another type of physical impairment, I consent to enter Family Physical Therapy and Wellness, LLC program for evaluation and treatment. I request and authorize the licensed staff of Family Physical Therapy and Wellness, LLC to render treatment, and to perform appropriate procedures that my referring provider may deem reasonable and necessary for my diagnosis. I understand that my physical therapy care and treatment may be provided by a physical therapist or physical therapy assistant. I am aware that there are certain risks involved with a physical therapy program. Every effort is made to minimize my risk by continuous assessment of my condition throughout my therapy. I will inform my therapist of any changes in my medical condition, or medications, as they may necessitate change in my therapy program. I will stop any procedure or activity and inform my therapist of any symptoms of pain, fatigue, shortness of breath, dizziness or nausea that may develop during my treatment. _____ (initials).

Privacy Notice Acknowledgement: As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I hereby acknowledge that I have had the opportunity to review a copy of Family Physical Therapy's (Notice of Privacy Practices". I understand that I am responsible to read this Notice and notify Family Physical Therapy and Wellness, LLC, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. Family Physical Therapy and Wellness, LLC has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times. I am aware that Family Physical Therapy and Wellness, LLC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains. Family Physical Therapy and Wellness, LLC will provide me with a copy of its most recent Notice upon my request. _____ (initials).

Requirement to Provide Proof of Current Insurance and Obtain Referral: I understand that it is my responsibility to provide Family Physical Therapy and Wellness, LLC with a copy of my current insurance card(s) and to obtain a referral from my Physician's office (if required by my insurance or after sixth visit per Georgia law). If I do not have insurance, I will be considered a Self-Pay patient and I am financially responsible for the total amount of the services provided. I will notify Family Physical Therapy and Wellness, LLC immediately upon any changes in my insurance. _____ (initials).

Insurance Waiver: I understand that if I do not have a copy of a current insurance card and valid referral, if required, Family Physical Therapy and Wellness, LLC is not obligated to see me, but if I still wish to be seen, I may be seen as a "Self-Pay" patient. I agree that neither Family Physical Therapy and Wellness, LLC nor I will file a claim for the visit. I will be required to pay the total cost of the visit at the time services are rendered. _____ (initials).

Payment: Co-payment is due on each day services are rendered. We accept cash or credit card (visa, master card, American express, or discover. If you have a co-insurance you will be billed your portion as it is processed by the insurance company. Payment will be due upon receipt of bill. _____ (initials).

Appointments/Cancellations: We typically see patients by appointment. Please call ahead if you think you will be late. We appreciate 24 hours notification of cancellations. You may leave a message on voicemail if you are calling after hours. If there are consistent lapses in scheduled attendance, you will incur a $25.00 for each visit missed, that will be assessed to your account. _____ (initials).

Adult Supervision: Those under the age of 16 receiving treatment at our facility must be accompanied by a parent or legal guardian during each physical therapy appointment. _____ (initials).

Other Information: I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records, not covered by my insurance plan. _____ (initials).

Consent to Release Forms: I hereby authorize the release of all information to Family Physical Therapy and Wellness, LLC to be held in strict confidence. I place no limitations on history or illness (including HIV and/or AIDS) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders, information to my referring physician, equipment vendors, and my insurance company coordinators or any other person financially responsible for my treatment for all purposes related to a claim for payment, and/or approval for services. _____ (initials).

By signing this agreement, I acknowledge that I have read, understand and agree to the above terms and conditions

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____