Tyler PHYSICAL THERAPY & PILATES

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Consent to Treatment/Privacy Policy/Assignment of Benefits

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills are handled.

EXPLANATION OF INSURANCE COVERAGE
Most insurance policies cover physical therapy, but this office does not ensure that yours does. Insurance policies can differ greatly in terms of coverage for physical therapy. Because of the variance of one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, as well as any unpaid balances in this office. We will verify your insurance coverage, and we will bill your insurance company in a timely manner.

I. Assignment of Benefits

Authorization of payment: I hereby assign all benefits directly to Tyler Physical Therapy. If my insurance carrier sends me payment for services incurred in this office, I shall send or bring the full payment to your office immediately upon receipt. I understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment in full.

_____ _____
Signature Date

II. Summary of Benefits

As a courtesy our office will contact your insurance to verify your coverage. This is not a guarantee of payment and is subject to change.
Deductible: $ _____ has been met; $ _____ not met
Coverage % _____ Co-pay $ _____

- Your insurance carrier(s) cover the following:
  _____ visit(s)/dollar(s) per calendar year.
- The following services are not covered by your insurance carrier:
  _____
- _____ Your insurance will not cover these services and you will be responsible for payment of the services you receive.

Terms of Benefits

This is a description of benefits, as given to us by your insurance company. This information is provided to you as a courtesy only. It is the patient's responsibility to check with your insurance to verify benefits/coverage. Summary of Benefits is not a guarantee of payment and is subject to change. I fully understand that any unpaid portion of services rendered is my responsibility. Quotes are an estimated calculation, according to the description of benefits given by my insurance company. I agree to the terms and conditions presented to me by Tyler Physical Therapy.

I acknowledge and accept the terms and conditions set forth in Sections I and II of this statement:

_____ _____
Signature Date

III. Consent for Release of Information

The undersigned authorizes the release of any personal health information required for treatment, payment or health care operation. This may include physicians, case managers and insurance carriers or third party payers. Further, the undersigned releases Tyler Physical Therapy to provide outside healthcare providers/services such information as is necessary to facilitate proper healthcare. In addition, the patient consents to the release of prior medical records from referring physicians, hospitals, case managers, or other entities, which have records necessary for proper evaluation and treatment of patient. All other uses and disclosure will be made only with your written authorization. You have the right to revoke authorization for further uses and disclosures at any time.

IV. Consent for Treatment

There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform. I consent to rehabilitation and incidental medical services at Tyler Physical Therapy. I understand the expected benefits, possible risks, side effects, complications and discomforts of my rehabilitation. I know and agree that Tyler Physical Therapy is not responsible for loss or damage to personally valuables.

V. Patient Responsibility

The patient is responsible for keeping all scheduled appointments, and for arriving on time. We require 24 hours notice for canceled appointments. Failure to do so will result in a penalty fee of $60.00. Patient's arriving late may have their treatment time adjusted accordingly.

VI. Privacy Policy

Tyler Physical Therapy will administer your records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. I have received a copy of the notice of Privacy Practices.

I acknowledge and accept the terms and conditions set forth in Sections III, IV, V and VI of this statement. Tyler Physical Therapy reserves the right to refuse service to anyone.

_____ _____

Patient's Signature **Date**

_____ _____

Witness' Signature (Staff) **Date**

CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian, I authorize Tyler Physical Therapy to treat the minor patient named in the attached forms while I am not present.

_____

Parent/Guardian Printed Name (Last, First) Parent/Guardian Signature Date

We hope this answers any questions you might have concerning financial policies of this office. Once again, we welcome you to our office and will be glad to answer any further questions you might have.