

Centered Health Physical Therapy

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Informed Consent for Treatment

The patient has the right to informed participation in decisions involving their care. This shall be based on clear, concise explanation of their condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by their attending physical therapist. The patient understands that there is no guarantee that the proposed course of treatment will improve their condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate their condition. The patient shall not be subjected to any procedure without their voluntary, competent and understanding consent or consent of their legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. After reading the above, I _____, hereby consent to receive physical therapy treatment at Centered Health Physical Therapy, LLC, commencing on _____ and terminating when determined by myself, my physician, or my physical therapist. I have read this information and understand its content.

Authorization to Release/Receive Information

The patient consents to Centered Health Physical Therapy, LLC, in its discretion, to disclose health information to any insurance carrier or their agents or designees, workers' compensation carriers, medical or utilization review organization, attorneys, etc., for the purpose of processing all or any portion of charges incurred relating to treatments received at Centered Health Physical Therapy, LLC. The patient further authorizes Centered Health Physical Therapy, LLC, in its discretion, to release records and/or medical information to any hospital, physician or other healthcare professionals as it relates to their treatment, as permitted/required by law. The patient understands that confidentiality of their health information is protected under state and federal law, and that this release gives consent to Centered Health Physical Therapy, LLC, only, and not to any party to whom such information is released.

Financial Policies

Assignment of benefits: The patient hereby authorizes and assigns direct payment to Centered Health Physical Therapy, LLC of any insurance or health plan benefits payable for the services rendered.

Guarantee of payment: The patient agrees to pay Centered Health Physical Therapy, LLC all charges NOT covered by insurance or health plan. In the event collection is undertaken, all costs associated with collections, including attorney fees, will be incurred by the patient or legal guardian.

Cancellation policy: If you need to cancel your appointment, we ask that you call at least 24 hours in advance so that we may offer your time slot to another patient. Failure to cancel in at least 24 hours will result in a \$50 charge - this is not covered by your insurance plan.

No Show policy: Failure to show up for your appointment will result in a 'no show' fee of \$100 - also not covered by your insurance plan.

Additional

Valuables release: I hereby release Centered Health Physical Therapy, LLC and any of its employees from any liability that may be incurred from any loss or damage of valuables and personal items that I have kept in my possession while in the facility.

Privacy information: My signature also confirms that I am informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Signature: _____ Date: _____

If signed by other than beneficiary, please state the reason why the patient was unable to sign and your relationship to the patient.
