BEAT Physical Therapy
Movement Specialists

Patient Name: _____ Date of Birth: _____

PATIENT CONSENT TO PHYSICAL THERAPY

CONSENT TO TREATMENT: INITIAL: _____

I consent to rehabilitation and related services at BEAT REHABILITATION AND WELLNESS, LLC (DBA BEAT PHYSICAL THERAPY). In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24-48 hours, I agree to contact my physical therapist.

I understand that my physical therapist will share with me his/her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before providing treatment. I understand that my physical therapist at BEAT PHYSICAL THERAPY, cannot make any promises or guarantees regarding a cure for or improvement in my condition.

TREATMENT OF MINORS: INITIAL: _____

I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY: INITIAL: _____

I understand and agree that BEAT PHYSICAL THERAPY is not responsible for loss, theft, or damage to personal valuables and belongings and hereby release BEAT PHYSICAL THERAPY from any liability arising out of such loss, theft or damage to personal belongings.

WAIVER AND RELEASE: INITIAL: _____

I hereby release, discharge and acquit BEAT PHYSICAL THERAPY, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT: INITIAL: _____

I hereby authorize and direct my insurance carrier and/or health plan to make payment directly to BEAT PHYSICAL THERAPY, of any benefits that would otherwise be payable directly to me for treatment and services provided by BEAT PHYSICAL THERAPY and hereby assign to BEAT PHYSICAL THERAPY all rights and interests I have in insurance proceeds or benefits otherwise payable to me for services rendered by BEAT PHYSICAL THERAPY.

I authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices.

I understand fully 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.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between BEAT PHYSICAL THERAPY and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize BEAT PHYSICAL THERAPY, to release all information necessary, including medical records, to secure payment.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Printed Name: _____

MISSED APPOINTMENT POLICY: INITIAL: _____

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater than 15 minutes may result in a shortened treatment or cancellation. It is our policy to reschedule any cancelled appointments for the same week at the time of your call. There is a $40 charge for a cancellation without a 24-hour notice. Attending your scheduled appointments is crucial to successful treatment and recovery from your injury.

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES POLICY:

I have received, understand, and agree to all information included and described in the BEAT PHYSICAL THERAPY Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Printed Name: _____

Witness: _____ Date: _____ Time: _____

MEDICARE PATIENTS ONLY:

I request that authorized Medicare benefits made to me or on my behalf be paid to the practitioner named above. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine benefits or the benefits payable for related services.

I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I have read this information and understand its content.

Patient Signature: _____ Date: _____ Time: _____

PATIENT INFORMATION CONSENT FORM

DISCLOSURE AUTHORIZATION – FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI):

I have read and fully understand BEAT PHYSICAL THERAPY Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that BEAT PHYSICAL THERAPY may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that that BEAT PHYSICAL THERAPY Physical Therapist will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I give my permission to BEAT PHYSICAL THERAPY to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related health-care provider, or other assignees as it relates to my treatment.

I further authorize BEAT PHYSICAL THERAPY to obtain medical records from my physician or other medical professionals as it relates to my treatment.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in BEAT PHYSICAL THERAPY's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Printed Name: _____

I give permission to BEAT PHYSICAL THERAPY to disclose and discuss any information related to my medical condition(s) including but not limited to date and time of appointments, account information, insurance information, and/or medical records with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

EMERGENCY CONTACT INFORMATION:

In the case of an emergency, I give my permission to BEAT PHYSICAL THERAPY to contact the following individual/s:

Name: _____ Relationship: _____ Phone #: _____

PATIENT CONTACT INFORMATION AND CONSENT FORM:

Please fill out below how you wish BEAT PHYSICAL THERAPY to contact you.

I wish to be contacted in the following manners(s): (Please check all that apply)

Home Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with family members or other persons living in the same

Work Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with family members or other persons living in the same

Cell Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with family members or other persons living in the same

Email (Please specify email address) _____

- ☐ OK to leave message with detailed information
- ☐ I would not like to be contacted via email

CONSENT TO RECEIVE APPOINTMENT REMINDERS:

BEAT PHYSICAL THERAPY offers email/voice/text reminders for upcoming appointments. These reminders can be canceled or changed at any time. Please fill out the below information if you would like to receive appointment reminders.

Yes, I would like to receive appointment reminders via:

- ☐ Voice Call to phone number: _____
- ☐ Text message to phone number: _____
- ☐ Email to email address: _____
- ☐ No, I would not like to receive appointment reminders

Patient/Guardian Signature: _____ Date: _____ Time: _____

Printed Name: _____