



PATIENT CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

1. CONSENT FOR TREATMENT: I hereby consent to, and authorize my physical therapist, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin and soreness after treatment, including, without limitation, myofascial release and soft tissue mobilization. I understand that my treatment may include, with my consent, examination of the pelvic floor performed either vaginally or rectally. I understand that it is my responsibility to inform my physical therapist if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that each patient's response to physical therapy intervention varies from patient to patient and it is possible that treatment may result in aggravation of existing symptoms or may cause inflammation of the condition for which I am seeking treatment.

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. ***I agree to provide notice to you at least 24 hours before if I need to cancel an appointment and I understand that cancellation of, or failing to keep an appointment with less than 24 hours prior notice will result in a cancellation fee of \$50.00. Cancellation fees cannot be billed to insurance and are my responsibility. I also agree that arriving more than 15 minutes late or departing more than 15 minutes early from an appointment will result in a \$25.00 fee that cannot be billed to insurance and is my responsibility.***

WORKER'S COMPENSATION PATIENTS (ATTENDANCE AGREEMENT): I understand that Pelvic & Orthopedic Physical Therapy Specialists ("POPTS) is required to inform my Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. I understand that any missed visits must be rescheduled per my authorized treatment plan and I must pay any cancellation fees.

3. RESPONSIBILITY FOR PAYMENT: All co-payments and self-pay services are due at the time of service. I acknowledge that in consideration of the services provided to me by POPTS, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide POPTS with my current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or health insurance benefits should be directed to my health insurance provider. I understand that my health insurance may pay for all or a portion of the services I receive from POPTS, but that I am responsible for any unpaid balance including, but not limited to, my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I understand that POPTS will bill my health insurance as a courtesy, but that I am responsible for any amounts not paid. I understand that auto insurance, worker's compensation and liability claims must be billed to a first-party carrier only. POPTS will not bill third-party carriers, will not file medical liens and will not wait for my bills to be paid after litigation is resolved. If formal collection procedures become necessary, I am responsible for any additional costs, including attorney's fees, incurred as a result of such collection procedures.

4. ASSIGNMENT OF BENEFITS: I hereby assign to POPTS all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with and to provide such information as is needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that POPTS may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I permit POPTS to provide information to any third party payer, insurance company, or agent which may be responsible in whole or part for paying my bill. I also permit the release of information to companies hired by these third parties to monitor utilization of rehabilitation services. I authorize my clinician(s) and POPTS's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment.

_____(initials) I acknowledge that POPTS has made the *HIPAA Notice of Privacy Practices* available to me and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

_____(initials) I acknowledge that I understand the *Appointment Attendance Agreement* and will be By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____(initials) I acknowledge that I understand the COVID-19 Addendum which I have also signed and delivered to POPTS.

Printed Name of Patient

Signature of Patient or Legally Responsible Person

Date

Printed Name of above (if not the Patient)

Date

Pelvic & Orthopedic Physical Therapy Specialists complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender.



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