Orthopaedic Physical Therapy and Associates, Inc
DBA: Premier Physical Therapy Services

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

Under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPPA), you have certain rights to privacy regarding your protected health information. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to your request for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. Premier Physical Therapy Services provides this form to comply with the Health Insurance Portability & Accountability Act of 1996 (HIPPA).

Designation of Those Who Can Receive Information About My Care

Designate the following individuals to have access to information about me that is created by you or on behalf of Premier Physical Therapy, and that this information can include PHI. I understand that I may revoke this designation at any time by completing a new form, and that this designation will not expire until I actively revoke it. I understand that these individuals will not be able to request a paper or electronic copy of my health records without having completed an Authorization to Release Medical Information form.

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

Permission to Leave Messages (Please <u>INITIAL</u> your selection)

_____ I give permission for Premier Physical Therapy to leave messages by voicemail, email or other form of communication regarding my appointments, billing concerns or a message from the therapist.

_____ I DO NOT give permission for Premier Physical Therapy to leave messages by voicemail, email or other form of communication regarding my appointments, billing concerns or a message from the therapist.

I authorize Premier Physical Therapy Services to perform treatment upon execution of this consent and I understand that I can refuse treatment at any time.

_____ _____
Patient Name (Please Print) **Date**

_____ _____
Patient/Guardian Signature **Date**

Patient Policies

Thank you for choosing Premier Physical Therapy for your physical therapy needs. We are committed to providing the highest quality of care for our patients. In order to do so, we need your assistance and acknowledgement of our policies.

Insurance/Billing Policies

- Please Provide us with the most recent copy of your insurance card(s) and a phopt ID. If you are not the insurance subscriber, we will need the name, date of birth and employer information concerning the subscriber.
- I authorize the payment of medical benefits to Premier Physical Therapy. I understand that I am financially responsible for all copayments, deductibles, co-insurance, and services NOT COVERED by my benefit plan.
- We will verify your insurance benefits as a courtesy to you. We rely on your insurance company to give is proper information but cannot guarantee accuracy, so if you feel there is a discrepancy, please bring it to our attention or contact your insurance company.
- If your insurance requires preauthorization and/or a referral for physical therapy, it is your responsibility to ensure that the referring physician or your PCP has obtained the necessary preauthorization. If we do not have the proper authorization, or referral at the time of your visit, it may be necessary to reschedule your appointment, or you will be required to pay for your visit in full. In the event that we are paid for the service by your insurance company, you will be reimbursed for the visit, less any applicable co=-pay or deductible.
- We required that a copayment, deductibles and supplies charges will be collected at the time of service and that patient remits payment for any balance due to continue services. A $10 administration fee will be assessed if this agreement is not met. If you have any questions regarding this process, please speak to our billing specialist.
- Failure to abide by this policy or if we do not receive payment within 30 days will result in the necessary action to collect payment. I authorize Premier Physical Therapy to contact phone or email regarding my delinquent account(s). I authorize Premier Physical Therapy and its agents, representatives, attorneys (including collection agencies) to use automated telephone dialing equipment, artificial pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due.
- Your credit card may be asked to be placed on file if account is not paid within 30 days. See credit card policy for more information. A copy can be provided to you at any time upon request.

Cancellations/Late Fees

Premier Physical Therapy Services expects that you make every effort possible to make your scheduled appointment on time. In the event you do have to cancel, we strongly encourage you to reschedule within 48 hours.

- **If you wish to cancel an appointment, we required a minimum 24 hour notice or a $35 fee will be assessed.**
- Your full attendance to therapy is the best way to an efficient recovery. If multiple occurrences happen, the following fees will be assessed: 2nd occurrence: $35, 3rd occurrence: $50, 4th or more: $75 and all future visits
- **If you are more than 15 minutes late to your appointment, a $20 fee will be charged.**

Appointment Reminders

Premier Physical Therapy is able to provide automatic appointment reminders by email **OR** cell phone text message. In the event the reminders do no work, you will still be responsible for remembering your appointments.

☐ I consent to receiving text messages from Premier Physical Therapy to the number provides. This may include appointment reminders. I recognize normal text messaging rates
Cell Phone: _____ Cell Phone Provider_____

☐ I consent to receiving email messages from Premier Physical Therapy to email address provided. This may include appointment information. I understand that these emails are unencrypted and are not secure.
Email address: _____

We would like to thank you in advance for your cooperation and understanding of these policies. We thank you for choosing Premier Physical Therapy. Your path to wellness begins here…

Patient Signature: _____ Date:_____