restorations physical therapy **Consent for Treatment/Financial Agreement/HIPAA & Acknowledgement**

CONSENT: You understand that physical therapy involves the use of many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. Restorations Physical Therapy is not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. You understand there is also a risk that treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is administering based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

RELEASE OF INFORMATION: You agree that the Facility may disclose your "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including , but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers. This includes appropriate release and disclosure of your medical records in compliance with Privacy Provisions to your physicians and other health care providers when necessary for your treatment and general health. While you are in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

FINANCIAL POLICY STATEMENT: As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill. You are responsible for payment of any co-payments at the time of service. If your insurance carrier does not remit payment once billed, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to Restorations Physical Therapy.

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

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

I, the undersigned, do hereby agree and give my consent for Restorations Physical Therapy to furnish Therapy Treatment. I understand my responsibility for payment of my account. 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.

Print Name:_____

On Behalf of:_____
Name of Child/Minor, or leave blank for self

Signed:_____ **Date:**_____
Patient/Guardian/Responsible Party

Please initial as appropriate:

_____ **I acknowledge that I have reviewed Restorations PT's privacy policy & have been offered a copy for my records.**

_____ **I acknowledge that I have reviewed Restorations PT's Patient Bill of Rights & Hours & have been offered a copy for my records.**

_____ **I would like to opt out of emails regarding Restorations PT's fundraising efforts.**