Consent for Treatment at Physical Therapy at Dawn

In the interest of providing our patients with the information required to make informed decisions regarding their care and their right to refuse care, we ask that you read the following:

Physical Therapy includes all procedures, techniques, and services provided by licensed physical therapists. Therapy includes joint responsibility for the improvement of health between the treating therapist and the patient. Therapy may include exercise specific to the condition which caused you to seek treatment, modalities for therapeutic effect, education regarding your condition, and/or manual therapy. Specific interventions will be suggested by your treating therapist. You are encouraged to ask questions to further your understanding of your therapy and are reminded that you may refuse treatment at any time. Refusal of treatment may result in the termination of therapy if the treating therapist determines that the refused intervention is essential to your success as a patient.

Your success and improvement during your time at Physical Therapy at Dawn is important to us and will help guide treatment decisions. It is essential for your success at Physical Therapy at Dawn that you attend all scheduled visits as your doctor and therapist prescribe. Please see the Attendance Policy below.

Attendance Policy

All future appointments will be cancelled in the event of a no show for an appointment. An exception to this would be made if we receive a call from you within the same day confirming your intent to attend the next scheduled appointment. Please leave a voicemail if you reach us before or after our business hours or if we are unable to answer the phone at the time you call. Our voicemail is checked regularly throughout the day. You may be discharged from physical therapy if you have more than one no show or cancellation under 24 hours during this episode of care.

Your signature below indicates your **Consent to be Treated** at Physical Therapy at Dawn, your acknowledgement of understanding of the **Attendance Policy**, your acknowledgement of receipt of the **Notice of Information and Privacy Practices**, and your acknowledgement of the **Financial Policy**.

Patient's Name: _____

Parent or guardian name
(If applicable):_____

Patient or parent/guardian
Signature: _____ Date:_____

Physical Therapy at Dawn

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Name under which you are insured: Last name: First: Middle:			Name you prefer to be called:	Today's date:
Birth date: / /	Age:	Sex: ❑ M ❑ F	Home phone no: ( )	Cell phone no: ( )
Address:				
City:			State:	ZIP Code:
Chose clinic because/Referred to clinic by: (Check all that apply)		❑ Dr.	❑ Insurance Plan	❑ Phone book
❑ Family	❑ Friend	❑ Close to home/work	❑ Albuquerque the magazine	❑ Other
Who is your Primary Doctor:				

INSURANCE INFORMATION

Date of Injury/Accident:				
Have you had Physical Therapy this year? ❑ No ❑ Yes (How many visits? _____)		Have you had home health this year? ❑ No ❑ Yes (When did it end? _____)		
Social Security Number:	Employer:	Occupation:	Employer phone no.: ( )	
Person responsible for bill(if other than you):	Birth date: / /	Address (if different):	Home phone no.: ( )	
Name of Primary Insurance:				
Policy/ID number:	Group number:	**Please bring card to front desk so we can make a copy for your file**		
Subscriber's name (if other than you):	Subscriber's S.S. no.:	Birth date: / /	Employer:	Policy no.:
Name of secondary insurance (if applicable):	Subscriber's name:	Policy/ID no.:	Group no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Physical Therapy at Dawn. I understand that I am financially responsible for any balance. I also authorize Physical Therapy at Dawn or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Notice of Information and Privacy Practices (HIPAA)

The privacy of your health information is an important issue. Please read the following regarding your rights as they relate to your protected health information (PHI).

It is our policy to fax a copy of your initial evaluation to your referring doctor as well as your primary care doctor.

Patients may request additional restrictions on access to their PHI:

1. Individuals have the right to agree or object to disclosure practices at this office. The Notice of Information Practices will inform individuals of this right. When a patient requires specific restrictions on disclosure of their health information, this information will be documented in the patient's record. The specific restrictions will be indicated and highlighted on the flow sheet with the actual restriction being placed behind the sign-in sheet in the medical record so the restriction will not be inadvertently violated.
2. Prior to disclosure of any PHI, every chart will be checked to ascertain whether or not the patient has requested additional restrictions on access to their PHI.
3. When a requested restriction pertains to uses and disclosures related to treatment, payment, and health care operations and it is determined that Physical Therapy at Dawn cannot comply with the request, the patient will be informed in writing. This information will be documented in the patient's record and maintained for six years.

Patients have the right to inspect and to receive copies of their health information (except psychotherapy notes and information in a criminal, civil, or administrative action):

1. Individuals may request access in writing. Physical Therapy at Dawn charges $1.00 a page for the first 10 pages and $0.50 a page for each page after that to help cover the printing costs. Physical Therapy at Dawn will have 30 days from receipt of the request to:
   (a) make the information available;
   (b) provide a written response to the individual indicating that the information is unavailable or has been destroyed; or,
   (c) provide a written notice to the individual indicating that access is denied.
2. When access is denied the notice will inform the patient of his or her right to appeal the decision through the Privacy Officer and/or by contacting the Secretary of HHS.
3. Provider must then promptly designate and refer the matter to a licensed health care professional who is not directly involved in the denial of review to review the decision to deny access. The reviewing official must determine, within a reasonable time, whether or not to deny access based on regulatory standards. The CE must promptly provide written notice to the individual of the determination and his or her appeal rights through the Secretary of HHS.
4. Any directive received from the Secretary of HHS regarding access to the record will be complied with.
5. All activities related to access will be documented and maintained in the patient record for six years.

Patients have the right to amend their health information:

1. Individuals may request the amendment in writing. Physical Therapy at Dawn will have 30 days from receipt of the request to:
   (a) accept the amendment,
   (b) provide a written response to the individual indicating that the information is unavailable and has been destroyed; or,
   (c) provide a written notice to the individual indicating that the request is denied and informing the patient of his or her right to appeal this decision by contacting the Secretary of HHS.
2. In any event, the patient may add his or her note to the record.
3. The provider will obtain the individual's identification of person's and entities to whom the amendment will be relevant, and authorization to inform these entities of the amendment or addition.
4. Provider will inform the relevant parties after receiving authorization.
5. Any directive received from the Secretary of HHS regarding access to the record will be complied with.
6. All activities related to access will be documented and maintained in the patient record for six years.

Financial Policy

Physical Therapy at Dawn is committed to providing you with the best possible care. In an effort to minimize confusion, we would like to take this opportunity to review our financial policies with you.

Cash Policy: If you do not have insurance coverage and will be paying on a cash basis, payment for your treatment will be due in full at the beginning of each treatment session. We offer a discount off our regular fee schedule.

Contracted Insurance Policy: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility.

1. Payment is due at the time of service for all co-pays, coinsurance, deductibles, and non-covered services. We accept cash, check, Visa and Mastercard.
2. If you have medical insurance, we are eager to help you receive your maximum allowable benefits.

A. Please provide us with complete information including a copy of your insurance card(s) for all primary and secondary insurance carriers at your initial appointment. If you have both primary and secondary insurance, you will be responsible for notifying us of which insurance is primary and which is secondary. If your insurance information changes during the course of treatment, please notify us immediately or you will be responsible for the balance of any unpaid bills.

B. As a courtesy, we will verify coverage and benefit eligibility. We would advise you to also check your benefits. Unfortunately, there are no guarantees of benefit reimbursement until claims are received and processed by your insurance company.

C. We will require you to assign all insurance payments directly to our office to avoid any misunderstandings regarding payment for professional services.

D. If any portion of your co-pay, coinsurance, and/or deductible is unmet at the time the claim is paid by your insurance carrier, you will be billed for the outstanding amount.

E. If you have an overpayment on your account after you have been discharged from your episode of care we will be happy to refund the overpaid amount to you within thirty days of receipt of the final payment from your insurance company for your episode of care.

Non-Contracted Insurance Policy: Physical Therapy at Dawn is not a party to your contract. As a courtesy, we will verify out-of-network eligibility and benefits and bill your insurance company if you want us to. You will be responsible for all monies due at the time of service. You can opt to be a "self pay patient" if you wish to be.

Litigated claims, Third Party Claims, or Letters of Protection: We do not accept litigated claims, third party claims, or letters of protection. If at any time during your treatment your claim becomes a third party liability, you will be required to pay for your services in full at each visit.

Workers' Compensation: We require approval/authorization from your workers' compensation carrier prior to your initial visit. If the claim is denied, you will be responsible for the payment in full if you decide to be seen in our clinic.

Medicare: If you have Medicare, we are required by law to file your claim with them. We cannot see you as a self pay patient. As a courtesy, we file your secondary insurance. If you do not have a secondary insurance, you will be required to pay your 20% portion of Medicare and your deductible if it has not been met. All payments are due at the time of service.

Divorce: In cases of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. All charges are due at the time of service.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We will send you a monthly statement that will show all paid and unpaid charges to the account. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month. If we have to refer the account to collections, you agree to pay all of the collection costs incurred, including attorney and/or court costs. In case of suit, you agree that the venue shall be Albuquerque, New Mexico.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to go to court, or if your past due status is reported to a credit reporting agency, the fact you received treatment in our office may become a matter of public record.

Returned Checks: There is a fee (currently $35.00) for any checks returned by the bank.

Effective Date: Once you have signed this agreement, you understand and agree to all the terms and conditions contained herein, and the agreement will be in full force and effect.