VERY IMPORTANT,

PLEASE READ ALL INFORMATION IN THIS PACKET

Insurance coverage policy

To accommodate our patients, we have enrolled in numerous insurance plans. With your cooperation, and our assistance, you should be able to receive all of the insurance benefits to which you're entitled. Each plan has its own restrictions regarding where and how often services may be rendered. If you have been in a motor vehicle accident relating to this visit, it is important to inform us prior to being seen to avoid being billed. We do not take third party payers.

It is your responsibility to understand your plan guidelines and inform us of any special requirements. Not doing so may result in uncovered services becoming your responsibility.

I have read and understand the above policy and agree to accept responsibility as directed.

Signed _____ Date _____

IF YOU ARE RECEIVING HOME HEALTH CARE, YOUR INSURANCE MAY NOT COVER YOUR VISITS HERE AT CRESTVIEW PHYSICAL THERAPY. YOU WILL BE RESPONSIBLE FOR ANY EXPENSES NOT COVERED.

Are you receiving any form of home health at this time?

_____

Signed _____ Date _____

NOTICE OF PATIENT RESPONSIBILITY POLICY

Please initial each section below:

____ **SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION** – As a member of a Physical Therapy program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services.

____ **MEDICAL NECESSITY** – If my insurance determines that a medical service and / or material is not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and / or material stated below.

____ **CO PAYS** – I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-pay cannot be waived at any time by the provider of service or the Crestview Physical Therapy Clinic.

____ **DEDUCTIBLES** – If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and / or provider. Yearly deductibles cannot be waived at any time by the provider of service or the Crestview Physical Therapy Clinic.

If you continue to miss appointments, your insurance company may decide not to pay. This will then become your responsibility to pay for all services rendered. Crestview Physical Therapy Clinic will mail, fax all notes and attendance records throughout your therapy to your insurance carrier.

Signed _____ Date _____

NOTICE OF PATIENTS RIGHTS

AS A PATIENT, YOU HAVE THE RIGHT TO:

- Participate in the development and implementation of your plan of care.
- Make decisions regarding your care.
- Have your report of pain taken seriously and to be treated with dignity and respect.
- Have your personal privacy respected.
- Receive care in a safe setting, free from verbal abuse or harassment.
- Confidentiality of your clinical records and the right to access information contained in your clinical records within a reasonable time frame (except in certain circumstances specified by law).
- Refuse any or all treatment.

SCHEDULING APPOINTMENTS

Crestview Physical Therapy Clinic will make every attempt to set appointments outside of the patient's work hours. However, it is impossible to do so in every case. If you have a scheduling preference, please let us know and we will attempt to accommodate your needs.

There is a $66 no-show / late-cancellation fee. All appointments must be cancelled at least 1 hour before scheduled appointment time, to avoid charges for a no-show or late-cancellation. After-hour messages regarding cancellations may be left at 682-7466. Insurance will not cover charges for no-show / late cancellation or eligibility fees.

WORKERS COMPENSATION PATIENTS

Continued missed appointments may affect Worker's Compensation Benefits. The Insurance carriers and physicians will receive a copy of the progress records, which include attendance records.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand that Crestview Physical Therapy Clinic (referred to below as "the clinic") will use and disclose health information about me in the course of providing physical therapy care to me.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to / or consult and coordinate with other health care providers in the course of my treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care, including provision of medical supplies and equipment, arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting / reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this clinic's Notice of Privacy Practices

By: _____ Date _____

(Patient)

-OR By:

_____ Date _____

(Patient representative)

Description of Representative's Authority: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ **Individual refused to sign**

☐ **Communication barriers prohibited obtaining the acknowledgment**

☐ **An emergency situation prevented us from obtaining acknowledgment**

☐ **Other (Please specify)**

_____

Crestview Physical Therapy Clinic
Consent to Release Information

Patient Name: _____
Date of Birth: _____

I authorize Crestview Physical Therapy Clinic to release information, records, or appointments on me to:

__ Insurance Company
__ Referring Physician
__ Staff at Crestview Physical Therapy Clinic
__ Spouse
__ Patient's Answering Machine
__ Other _____

- I understand that I do not have to sign this authorization and that my refusal will not affect my abilities to obtain treatment.
- I may cancel this authorization any time by submitting a written request to Crestview Physical Therapy Clinic.

I am the individual to whom the information/record applies or the person's parent (if minor) or legal guardian. I authorize this release of protected health information.

Signature: _____ Date:

This authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print Name

_____
Signature

Relationship to patient: _____

PATIENT INFORMATION

PATIENT INFORMATION

Patient Name:	Social Security No.	Age	Date of Birth
Address:	City	State	Zip Code
Referring Physician:	Home Phone		Cell Phone
Primary Dr	Work Phone		Email address:
How did hear about us?			

RESPONSIBLE PARTY INFORMATION

Person responsible for medical expenses	Relationship	Phone Number
Address:	City / State	Zip Code

INSURANCE INFORMATION

Primary Insurance:

Main subscriber for insurance (Name):			Relationship
Social Security No.	Date of Birth	Policy No.	Group No.

Secondary Insurance:

Main subscriber for insurance (Name):			Relationship
Social Security No.	Date of Birth	Policy No.	Group No.

EMERGENCY INFORMATION

Person to contact in case of Emergency:	Phone Number:		Relationship
Address:	City	State	Zip Code

CONSENT FOR TREATMENT - RELEASE OF MEDICAL INFORMATION

I consent to treatment necessary for the care of the patient mentioned above. I hereby authorize the release of all medical records to the referring and family physician, and to any other person(s), organization(s), and/or company(s) involved in my care or rehabilitation, with the following exceptions:

Signature of patient or guardian: _____ Date: _____

FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered and agree to make definite financial arrangements for payment. I understand that the charges made for professional services may not be covered in full by my insurance company and, therefore, where applicable, the patient or responsible party is solely responsible for payment of all services. I further request that insurance payments be made either to me or to Crestview Physical Therapy Clinic for any amount not already paid by me for charges incurred for treatment of my medical condition.

Signature of patient or guardian: _____ Date: _____