HARTER Physical Therapy
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Goddard, KS 67052
Ph: (316) 550-6132
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Patient Consent to Physical Therapy

1. **CONSENT TO TREATMENT**: I consent to rehabilitation and related services at Harter Physical Therapy, LLC. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. I understand that my physical therapist will share with me his/her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before providing treatment. I understand that my physical therapist at Harter Physical Therapy, LLC, cannot make any promises or guarantees regarding a cure for or improvement in my condition.
2. **TREATMENT OF MINORS**: I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
3. **LIABILITY**: I understand and agree that Harter Physical Therapy, LLC is not responsible for loss, theft, or damage to personal valuables and belongings and hereby release Harter Physical Therapy, LLC from any liability arising out of such loss, theft or damage to personal belongings.
4. **WAIVER AND RELEASE**: I hereby release, discharge and acquit Harter Physical Therapy, LLC, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.
5. **AUTHORIZATION OF PAYMENT**: I hereby authorize and direct my insurance carrier and/or health plan to make payment directly to Harter Physical Therapy, LLC of any benefits that would otherwise be payable directly to me for treatment and services provided by Harter Physical Therapy, LLC and hereby assign to Harter Physical Therapy, LLC all rights and interests I have in insurance proceeds or benefits otherwise payable to me for services rendered by Harter Physical Therapy, LLC. I authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.
6. **ACKNOWLEGEMENT OF RECEIVAL OF NOTICE OF PRIVACY PRACTICES POLICY:** I have received, understand, and agree to all information included and described in the Harter Physical Therapy, LLC Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Printed Name: _____

Witness: _____ Date: _____ Time: _____

Medicare Patients Only

I request that authorized Medicare benefits made to me or on my behalf be paid to the practitioner named above. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I have read this information and understand its content.

Patient Signature _____ Date: _____

FINANCIAL POLICY

Thank you for choosing Harter Physical Therapy, LLC as your Physical Therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy. Please read, initial after each section, and sign prior to your treatment.

Payment of services is due prior or upon completion of each treatment visit. We accept CASH, DEBIT CARD, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS or PERSONAL CHECKS. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

INITIALS_____

Private Insurance

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date of services rendered. You are also responsible for any deductible and co-pay. It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. At this point, there may be more due on your account. In this event, we will mail you a statement or if you prefer, will send the statement to your email, and appreciate your prompt payment.

-Regarding insurance plans where we are a participating provider, we will take the contracted rate assigned by the insurance company and make the proper adjustments to your claim.

INITIALS_____

Non-Covered Expenses

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are directly responsible for payment of medical supplies. You may be responsible for payment of charges denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

INITIALS_____

Secondary Insurance

If you have a co-pay with your primary insurance, and you have a secondary insurance, we will as a courtesy to you submit this to your secondary insurance a maximum of two times. If no payment is received or your secondary insurance does not respond, you will be billed and expected to pay the balance, at which time you will be given a "paid" receipt that you will then be able to submit to your secondary insurance for reimbursement.

INITIALS_____

Missed Appointment Policy

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater than 15 minutes may result in a shortened treatment or cancellation. It is our policy to reschedule any cancelled appointments for the same week at the time of your call. **There is a $25 charge for a cancellation without a 24 hour notice.** Attending your scheduled appointments is crucial to successful treatment and recovery from your injury.

INITIALS_____

Balance Accrual Policy

If your account has accrued a balance of over $100.00, we will require some form of payment prior to your next therapy session. If you are having difficulty with payments, please speak with us before canceling appointments. **Unpaid balances over 60 days will be charged a $30.00 late fee.**

INITIALS_____

Returned Checks Policy

Returned checks will be subject to **$30.00** collection charge in addition to the original check amount.

INITIALS_____

I have read, understand, and agree to this Financial Policy. I am also aware of, and understand my policy benefits for treatment.

Patient/Guardian Signature: _____ Date _____

Printed Name: _____

PATIENT INFORMATION CONSENT FORM

Disclosure Authorization – For Release of Protected Health Information (PHI)

I have read and fully understand Harter Physical Therapy, LLC's Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that Harter Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that that Harter Physical Therapy, LLC's Physical Therapist will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I give my permission to Harter Physical Therapy, LLC to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related health-care provider, or other assignees as it relates to my treatment. I further authorize Harter Physical Therapy, LLC to obtain medical records from my physician or other medical professionals as it relates to my treatment.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Harter Physical Therapy, LLC's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature:_____ Date: _____

Printed Patient Name: _____

I give permission to Harter Physical Therapy, LLC to disclose and discuss any information related to my medical condition(s) including but not limited to date and time of appointments, account information, insurance information, and/or medical records with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact Information

In the case of an emergency, I give my permission to Harter Physical Therapy, LLC to contact the following individual/s:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Patient Contact Information and Consent Form

Please fill out below how you wish Harter Physical Therapy, LLC to contact you.

I wish to be contacted in the following manners(s): (Please check all that apply)

Home Telephone
□ OK to leave message with detailed information
□ Leave message with call-back number only
□ OK to leave message with family members or other persons living in the same

Work Telephone
□ OK to leave message with detailed information
□ Leave message with call-back number only
□ OK to leave message with family members or other persons living in the same

Cell Telephone
□ OK to leave message with detailed information
□ Leave message with call-back number only
□ OK to leave message with family members or other persons living in the same

Email (Please specify email address) _____
□ OK to leave message with detailed information
□ I would not like to be contacted via email INITIALS_____

Consent to Receive Appointment Reminders

Harter Physical Therapy, LLC offers email/voice/text reminders for upcoming appointments. These reminders can be canceled or changed at any time. Please fill out the below information if you would like to receive appointment reminders.

Yes, I would like to receive appointment reminders via:
□ Voice Call to phone number: _____
□ Text message to phone number: _____
□ Email to email address: _____

□ No, I would not like to receive appointment reminders

Patient Signature: _____ Date: _____

Printed Name: _____