HIPAA CONSENT FORM

By signing this form, you are granting consent to U-District PT to use and disclose your protected health information and electronic protected health information to a third party provider for the purposes of treatment, payment, and health care operations. U-District PT will not disclose your protected health information without your consent. The Notice of Heath Insurance Portability and Accountability Act of 1996 provides more detailed information about how we may use and disclose this protected health information. It is your right to review our Notice of Privacy Practices before you sign this consent and may ask to read it in full at any time.

U-District PT's Notice of Privacy Practices is subject to change and you have the right to request the revised notices by contacting us.

You have the right to request a restriction of how your protected healthy information is used. U-District PT is not required to agree to the request but if the clinic does agree we must follow these restrictions.

You have the right to revoke this consent in writing at any time, however U-District PT may still use this information to complete any actions that began prior to you revoking consent.

U-District PT may refuse your services if you refuse to sign this contract.

With this consent U-District PT may call my home or other alternative phone numbers and leave a message on voicemail or to any person answering the phone in reference to any items that assist the office in carrying out treatment, payment, and health care operations; such as appointment reminders, insurance items and any calls pertaining to my clinical care.

Print Name: _____ Date: _____

Signature: _____

(Patient or Guardian if patient is a minor)

U DISTRICT PT
PHYSICAL THERAPY

SCHEDULING POLICY

We request **24 hours'** notice by phone call to reschedule appointments. We reserve the right to discharge your case without notice if you:

-**No Show** (no notice of missed appointment) two appointments OR

-**Cancel** (cancelling the day of appointment) three times in a row

Please provide your email address _____ for appointment reminders. You will be sent an appointment reminder a day prior to your scheduled appointments.

Signature: _____ Date: _____

(Patient or Guardian if patient is a minor)

WELCOME LETTER

INSURANCE INFORMATION: As a courtesy to you we will bill your insurance company. Please provide us with your insurance card(s) and any additional information we may need during your first visit. We recommend that you call your insurance company to verify your physical therapy coverage. It is your responsibility to know your policy benefits and limitations. Our billing office is available to answer questions you may have regarding our billing procedures. Please be aware that costs for each session may periodically differ.

PAYMENT OPTIONS: We accept personal checks, cash, VISA and MasterCard. Insurance co-payments are due at the time of service. If we have to bill your co-pay a service will may be applied to your bill. Any portion of your treatment that is not covered by your insurance becomes your responsibility and is due within 30 days. Interest may be charged at a rate of 1% each month (12%) annually) for unpaid balances over 30 days old. A $25 fee will be charged for all checks returned as insufficient funds.

WORKER'S COMPENSATION CLAIMS: We will bill your OPEN, approved Worker's Comp Claim. Please be advised that in the event your claim is denied you are financially responsible for all charges.

NON-DISCRIMINATION: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

MEDICARE PATIENTS: Medicare requires you to see your doctor 60 days from the start of your physical therapy treatment and every 30 days after in order to continue with physical therapy. Without a current prescription Medicare can deny payment.

PHYSICAL THERAPY SUPPLIES: If there are supplies need to be purchased by the patient in order to carry out home exercises or treatment payments for these supplies are due at time of service. We will provide a receipt to you so you may seek reimbursement from your insurance company. Supplies are not refundable.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or your insurance coverage please do not hesitate to ask for our assistance.

Signature: _____ Date: _____

(Patient or Guardian if patient is a minor)