Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/ health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my dedicated appointment time. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/ no show charge of $25.

WORKERS COMPENSATION PATIENT: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/ or Rehabilitation Manager of all missed, canceled, or rescheduled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at time of service. I acknowledge that in consideration of those services - provided to me- I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may decide that a portion of the charges and balance will remain my personal responsibility, such as by deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to all my rights and claims for reimbursement under my insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that my documented medical and other information related to my treatment will be used in the course of my treatment in electronic and other forms, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. **HIPAA CONSENTS:** In accordance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding scheduled appointment, the treatment I receive and the billing of my account:

______________________________	______________________________	______________________________
Name/ Relationship	**Name/ Relationship**	**Name/ Relationship**

I also authorize the release of appointment information left in a voice-mail, answering machine, text message or email and understand that there is some level of privacy risk associated with these forms of communication.

By signing my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

____   ________________________

Signature of Patient or Legally Responsible Person   **Date**

____

Printed Name of Above

New Patient Intake

Patient Name: ______________________________________ DOB: ______________________

Primary Care Physician: ___________________________ Phone: _______________________

Employment Information

Full-Time Part-Time Self-Employed Not Employed

Retired Student Active Duty

Employer Name: ____

Employer Address: ____

Work Phone: _________________________________

Job TItle: ____________________________________

Responsible Party (Must be parent or legal guardian if the patient is a minor.)

Last Name: ________________________ First Name: _________________________ MI: ____

Date of Birth: _______________________ Gender: ______________

Address: ____ APT: __________

City: _______________________________________ State: __________ Zip: _____________

Home Phone: ____________________________ Cell Phone: ____________________________

Email: __________________________________ Relationship to Patient: __________________

____ ____________________

Patient Signature/ Patient's Responsible Party/ Patient's Legal Representative *Date*

Patient Communication Authorization

Complete this form and sign below to give your authorization for Wichita Physical Therapy Group to provide automatic appointment reminder services by email. By authorizing us to do so, you acknowledge understanding that there is some level of privacy risk associated with these forms of communication.

Patients First and Last Name: ____

Select Options Below:

- ☐ Email communication for upcoming appointments and Home Exercise Programs.

  Email: ____

- ☐ I prefer not to be contacted by email for upcoming appointments.

Please understand that there may be times that these reminders are not functioning properly due to system issues that we may not be aware of. While we are committed to resolving any issues that arise, these reminders cannot be guaranteed and you should not solely rely on these reminders for your appointments. We ask that you, as the patient or patient's responsible party, still ultimately be responsible for your schedule. We at Wichita Physical Therapy Group are patient advocates and will do our best to work with you to provide great customer service.

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Signature of Patient or Guardian

____

Date