WICHITA PHYSICAL THERAPY GROUP

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. The purpose of this notice is to inform self-referred patients that physical therapy diagnoses are distinct from medical diagnoses.

3. **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.

4. **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.

5. **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.

6. **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.

7. **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



WICHITA PHYSICAL THERAPY GROUP

New Patient Intake

Patient Name: _____ DOB: _____

Patient Address: _____

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.)

Please complete this section with insurance policy holders information.

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***

Print Name: _____

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Patient Communication Authorization

Complete this form to authorize Wichita Physical Therapy Group to send appointment reminders, balance notifications, and patient statements via email and/or text message.

By signing below, you acknowledge that electronic communications are not encrypted and may carry some level of privacy risk.

Communication Preferences (check all that apply):

- ☐ Email communication
- ☐ Text message communication

Preferred Email: _____

Cell Phone Number: _____

These communications may include appointment reminders, balance due notifications, and patient statements. Detailed clinical or diagnostic information will not be sent electronically.

Standard message and data rates may apply.

Our communication systems may occasionally experience technical issues beyond our control. Appointment reminders are not guaranteed, and patients remain responsible for attending scheduled appointments.

I understand that I may revoke this authorization at any time by notifying Wichita Physical Therapy Group.

At Wichita Physical Therapy Group, we are committed to patient advocacy and excellent customer service.

_____

Signature of Patient or Guardian

_____

Print Patients First and Last Name

_____

Date

Media Release Form

I hereby authorize **Wichita Physical Therapy Group and its agents** to use, reproduce, and publish photographs, testimonials, statements, and/or video content ("Content") that may contain my image, likeness, and/or voice. I agree and understand I shall neither be compensated for the Content nor receive attribution for the Content.

I also attest that I am authorized to grant to **Wichita Physical Therapy Group and its agents** the right to use this Content. I understand that this Content may be used in publications, press releases, marketing materials, advertisements (both digital and print), websites (including social media sites), or other uses. This authorization is continuous, and only I may withdraw this authorization through specific, written rescission.

I hereby release **Wichita Physical Therapy Group and its agents** from any liability of any kind related to the use, reproduction, or publication of the Content

Print Name: _____

Signature: _____

Date: _____

Phone Number: _____

Address: _____

_____

WICHITA PHYSICAL THERAPY GROUP

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