PHYSIOCARE
PHYSICAL THERAPY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for PhysioCare. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to PhysioCare to release any of my protected healthcare information.

Patient/Legal Representative Signature: _____

CONSENT FOR CARE AND TREATMENT

I understand that my therapist will complete an evaluation by examination and interview. An individual treatment program will then be designed which may include a variety of treatment techniques. I do hereby agree and give my consent for care and treatment considered necessary and proper as directed by my referring provider and/or licensed therapist employed by PhysioCare.

Patient/Legal Representative Signature: _____

LATE ARRIVAL/CANCELLATION/NO SHOW POLICY *(Please initial by each statement below)*

_____ I understand that if I am late for an appointment, I will be seen as the therapist's schedule permits. I may not receive all or any of my treatment and may have to reschedule my appointment.

_____ I understand I need to call PhysioCare within 24 hours of my scheduled appointment if I need to cancel and/or reschedule. Should I fail to give 24-hour notice of cancellation or fail to show up for my scheduled appointment, I may be subject to a $40 charge which is not covered by insurance.

_____ I understand that if I consistently cancel my appointments and/or fail to show up for 3 consecutive appointments PhysioCare has the right to terminate services due to non-compliance with the rehabilitative Plan of Care.

PAYMENT AUTHORIZATION *(Please initial by each applicable statement below)*

_____ ASSIGNMENT OF INSURANCE BENEFITS: I authorize that the payment of my insurance benefits be made directly to PhysioCare for all services delivered; if I am paid directly I will promptly pay PhysioCare all monies paid to me.

_____ GUARANTEE OF PAYMENT: I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date.

_____ CERTIFICATION OF INFORMATION: I certify that the information I have provided PhysioCare for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

_____ **AETNA MEMBERS:** I understand that after **25 visits of therapy** Aetna requires a utilization management review to determine if further treatment/coverage on my behalf is medically necessary. I understand that as an Aetna member, if **I choose to continue treatment during the utilization management review period and it is later determined that treatment/coverage is NOT medically necessary, I will be held financially responsible for all denied claims.**

_____ **REGENCE BOEING MEMBERS:** I understand that after **3 months of therapy** Regence requires a utilization management review to determine if further treatment/coverage on my behalf is medically necessary. I understand that as a Regence Boeing member, if **I choose to continue treatment during the utilization management review period and it is later determined that treatment/coverage is NOT medically necessary, I will be held financially responsible for all denied claims.**

Patient/Legal Representative Signature: _____ Date: _____