Thank you for choosing **BODY REBUIlDERS** for your physical therapy needs. Our goal is for you to achieve the best outcome in a comfortable friendly environment. To provide the best service, it is important that you understand our policies and procedures. Please carefully read each section below, sign and date. Feel free to ask if you have any questions concerning our policies.

**CONSENT FOR TREATMENT**

The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy have been explained to you. The physical therapist will provide information at the initial visit regarding potential treatment options available for your condition before you consent for treatment. All procedures will be thoroughly explained to you before they are performed.

There are certain inherent risks with physical therapy treatment. You may be asked to exert effort and/or perform activities with increasing degrees of difficulty. These activities may cause an increase in your current level of pain or discomfort, or an aggravation to your existing injury. This discomfort is usually temporary. If it does not subside within 24 hours, you are advised to contact your physical therapist.

There are many potential benefits from physical therapy intervention which may include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience decreased pain and discomfort. You should gain a greater knowledge about managing your condition and the resources available to you.

If you do not wish to participate in the therapy program, you can discuss alternatives with your therapist or referring physician.

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By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

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Print Name Patient Signature Date

**PHYSICAL THERAPY PRESCRIPTION**- PA state law requires that a patient have a current prescription from a physician, PA, or CRNP to receive physical therapy treatment. Prescriptions remain valid for up to 30 days from date written. It is the patient’s responsibility to provide a current prescription from the referring physician to obtain treatment.

**REFERRAL**- If your insurance requires a referral from your PCP for physical therapy, the referral must be obtained by the patient prior to the first visit. If the referral is not obtained, the patient is responsible for charges for the services rendered.

**DIRECT ACCESS**- Certain physical therapists at Body Rebuilders have a valid direct access physical therapy license and may provide therapy treatment for the first 30 days without a physician’s prescription. A direct access physical therapist may request you to consult a physician at any time during your treatment at their discretion. After 30 days of treatment, it is the patient’s responsibility to provide a prescription for continued treatment from a referring physician, PA or CRNP or he/she will be unable to continue care.

**CANCELLATION AND ATTENDANCE POLICY**

We are committed to your rehabilitation. In order to meet your rehabilitation goals, it is extremely important that you attend your physical therapy appointments as recommended by your physical therapist and physician. In an event you cannot attend a scheduled appointment, we ask that you call **24 hours** in advance. If you cancel in less than 24 hours, or miss your scheduled appointment, we will charge a **$25 cancellation fee.** Cancellation fees are not billable to your insurance and must be satisfied to continue treatment. \_\_\_\_\_\_\_ Initials

**FINANCIAL POLICY**

Prior to initiating your care, it is important that you understand your financial responsibility. It is your financial responsibility to ensure payment of our fees in full. We will attempt to verify your insurance and will bill your insurance carrier on your behalf if applicable. We ask that you take responsibility for being aware and knowledgeable of the coverage and benefits offered by your health insurance. We will do our best to help you; however, because of the many different plans and benefits available, we cannot be fully knowledgeable about all aspects of your coverage. If your insurance coverage changes during your treatment, please notify us immediately so we can best help you to be properly reimbursed.

**Patients are responsible for co-payments, co-insurance and/or deductibles and payment for services or goods not covered by your insurance carrier.** Copays will be collected at the time of each visit. You will receive monthly statements of your account activity. Please make sure we have your current address on file. Please remember that your insurance plan is a contract between you and your insurance carrier. We will act on your behalf to obtain payment for our services. Once we have exhausted all efforts; the patient is responsible for the balance due. For your convenience our office accepts payment by Visa, Mastercard, American Express in addition to cash and personal checks. There will be a $25.00 fee for all returned checks. We do not accept letters of protection in litigation cases.

**SELF-PAY POLICY**- Patients without insurance coverage who wish to receive care may do so at a self-pay rate. The patient is solely responsible for the bill. Payment is due at time of rendered service.

**COLLECTION ACCOUNTS**- Accounts that are delinquent for more than 3 months will be turned over to a collection agency. If your balance goes to a collection agency, you agree to reimburse us the fees of the collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all expenses, including reasonable attorneys’ fees, we incur in such collection efforts. All debts must be satisfied before returning for a new course of physical therapy.

**ASSIGNMENT OF INSURANCE BENEFITS**

I have read the above policy outlining my financial responsibility to Body Rebuilders, PC for providing physical therapy services to me or the above-named patient. I certify that the information I have provided is, to the best of my knowledge, true and accurate. I authorize release of any medical information needed to process my claim. I authorize release of payment directly to Body Rebuilders for physical therapy services rendered. I understand that I am responsible for any charges that are not covered by my insurance.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF INFORMATION PRACTICES**

By signing below, I acknowledge that I have received a copy of Body Rebuilders Physical Therapy’s **Notice of Privacy Practices**. I give permission to Body Rebuilders, PC to use and disclose my health information in accordance with its terms. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. \_\_\_\_\_\_\_\_ Initials

Office use only \_\_\_\_\_ Refused to Sign \_\_\_\_\_\_ Refused Copy