

New Patient Acknowledgements

Patient Name: _____

Date of Birth: _____

Consent to Evaluate and Treat

Initial _____

I do hereby consent to the evaluation and treatment by Redwood Physical Therapy. I understand that it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Notice of Privacy Practices

Initial _____

I hereby acknowledge that I have reviewed Redwood Physical Therapy Notice of Privacy Practices and agree to the practice's use and disclosure of my protected health information for treatment, payment and health care operations. I further acknowledge that a copy of the current notice is available at the front desk and online, and that I may request a copy of any amended Notice of Privacy Practices at any time.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

Release of Information

Initial _____

I authorize Redwood Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third-party payor or other entity providing payment for my health care (such as insurance company, employer, or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information for communication and care coordination on my behalf to: _____

Assignment of Benefits

Initial _____

I request that payment of Medicare and/or other insurance benefits be made on my behalf to Redwood Physical Therapy for any services furnished by Redwood Physical Therapy.

Financial Agreement

Initial _____

The undersigned agrees, whether signing as agent or patient, that she/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Redwood Physical Therapy. Redwood Physical Therapy will verify insurance benefits on behalf of the patient as a courtesy. However, verification is **not a guarantee** of payment and patients can call their insurance companies as well to confirm this information. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

Insurance Coverage

Initial _____

I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I will be held responsible for any

balances not covered by said insurance. This includes balances due to lack of authorization. **Initial Choice:** ___ I do not have secondary coverage. ___ I choose not to use my secondary coverage.

Insurance Benefits

Initial _____

Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contract with us still exists and you are responsible for payment personally.

Your Responsibility

Initial _____

Co-pays, deductibles, and self-pay payments are due at the time of service. We accept Mastercard, Visa, cash, check or money order **only**. We will assist with a budgeted payment plan based on individual need. In any event, if you request such a plan, this will be set up directly with our practice billing department. If at any point you have a problem regarding billing and payment please speak with the Office Coordinator of the clinic.

Cancellation Policy

Initial _____

We require 24 hours notice in the event of a cancellation. It is your responsibility when you call in to have an alternative time in mind that will ensure you receive your full prescribed number of treatments that week whenever possible. There is a \$25.00 charge for a no show or cancellation without proper notice. This charge will not be covered by your insurance company, and will have to be paid by you personally. You should understand that when you no-show, three people get hurt: 1) yourself, because you are not receiving the treatment you need as prescribed by the doctor and our staff, 2) the therapist, who now has a “vacancy” in their schedule since the time was personally reserved for you, and 3) another patient, who could have been scheduled for treatment if you had given us proper notice.

Arrival Policy

Initial _____

If you are late, we may not be able to provide your full treatment. If you arrive early we will do our best to get you in as soon as possible. Most of the time you’ll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

Patient Signature (Parent/Guardian if patient under 18 years)

Printed Name

Date