Consent and Conditions of Service Form

Patient Name (Last, First, MI)	**Date of Birth (MM/DD/YYYY)**	(Office Use Only) **Witness Initial: _______**

Welcome to Therapy West Physical Therapy (TWPT). Thank you for choosing TWPT to be your therapy provider. Our therapists are licensed and trained to use evaluation and treatment techniques to help restore you to your optimal activity level. As with all medical care, we are obligated to inform you that there are potential risks associated with treatment. Since the physical response to therapy can vary widely from person to person, it is not always possible to predict your response to certain exercises or procedures. It is possible that therapy may cause pain, injury, or may aggravate previously existing conditions. We encourage you to communicate openly with your therapist during the evaluation and treatment process. You have the right to decline any portion of your treatment at any time before or during a treatment session.

Release of Information and HIPAA/Privacy Acknowledgment: TWPT is required by law (Office of Civil Rights) to protect the privacy of your medical records. TWPT uses and discloses medical records ONLY in accordance with state and federal privacy laws (HIPAA). Uses and disclosures are described in TW Notice of Privacy Practice. You may request a copy of this document at any time.

Financial Responsibility:
I (Patient or Authorized Representative) agree to pay for any amounts not paid by an insurance company or other third-party payer (excluding contract discounts) for care provided. I understand that I am responsible for all co-payments, deductibles, co-insurances, and/or non-covered services.

Unresolved Account Balance:
I understand that I carry the full responsibility of any unresolved balance and I understand and agree that any remaining balance on my account not paid within 30 days of the statement date, or according to terms of a payment plan, will be sent to a collection agency. If I choose not to pay for care provided, and in the event an unpaid balance is placed with a collection agency or attorney, I agree to pay the unpaid balance and associated collection fees.

For Medicare/Medicaid/Tricare/Veterans Administration Patients' Certification Only:
I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act, or in connection with any other government program, is correct. I authorize Therapy West Physical Therapy to release documentation regarding my therapy services to the Social Administration, fiscal intermediary, insurance payer, or state agency in order to process a claim for my therapy services.

Assignment of Benefits:
I request and authorize my health insurance carrier to pay Therapy West Physical Therapy directly for all charges related to services provided to me by TWPT or other providers who have authorized TWPT to bill on their behalf.

Payment Options:
Therapy West Physical Therapy accepts cash, check, VISA or MasterCard for payment of services or products. TWPT understands the importance of physical therapy and as such, TWPT offers a few payment plans so our patients can receive the care they need. If you need a payment plan, please talk with our patient care coordinators and we can assist you with this.

Reminders/Account Balances:
I authorize TWPT to send appointment reminder/account balances/copay amounts either via text, email and/or phone. If I would not like to receive a reminder, I will notify the front desk upon my first appointment.

Patient Medical Record Authorization:
I authorize TW to provide my confidential information to the following individual(s).

Name____Relationship to Patient________________________

Cancellation/No Show Policy
Our schedule is very full and certain time slots are not always available to patients who need them. For this reason, we have a 24 hour cancellation policy. If you cannot make a scheduled appointment, for any reason, we require 24 hours' notice of the cancellation. When you call we will assist you in rescheduling this appointment because your optimal improvement and recovery is our main goal.

Certain accident claims expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis, it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you 'back in the game' of life. Missing appointments hinders that process and may end up prolonging recovery, or denial in claims.

While we understand that illness can strike at any time, repeated cancellations for illness without 24 hours notice will not be an acceptable excuse for untimely notice.

Success in rehab depends upon following your plan of care. Consistent attendance results in the most expedient and best outcome. Just as it is important to finish a course of antibiotics for effective treatment, it is also imperative to finish your full plan of care.

A "no show" (no communication about missed appointment) will be charged a $35 fee ($50 for an EMG appointment). You also understand that an appointment cancelled with less than 24 hours notice will be charged a $25 fee. The fee will need to be paid at your next appointment, in order to continue care. THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE AND IS YOUR RESPONSIBILITY!

We understand that extenuating circumstances sometimes occur, which is why we have implemented a strike out policy. We will allow one no-show and two cancellations without 24 hours notice before we will apply the no-show and cancellation fees.

My signature below acknowledges my understanding of the TWPT Consent and Conditions as stated above.

Signature:	**If signee is someone other than the patient, what is relationship?**	**Date:**