TRUE Physical Therapy PA
2081 N Webb Rd.
Wichita KS, 67206
(316)260-8239

Consent to Treat / Privacy Policy

Printed Name_____

1. I hereby give TRUE Physical Therapy P.A. consent to treat my prescribed injury.
2. I hereby acknowledge that I understand TRUE Physical Therapy's Notice of Privacy Practices and HIPAA.
3. I give TRUE Physical Therapy P.A consent to release ☐medical information and/or ☐insurance information to the people listed below.

Name:_____ Relationship:_____
Name:_____ Relationship:_____

4. I give TRUE Physical Therapy P.A. permission to leave phone messages regarding my physical therapy care at the number listed below. This consent will remain valid until revoked in writing.

Cell #_____Home #_____Work #_____

Financial Policies

1. I agree to pay for equipment and supplies not covered by the contract between TRUE Physical Therapy P.A. and my insurance company.
2. Estimated payment is required at the time of service. This includes, but not limited to all copayments, co-insurance, and deductibles. Office Manager must approve payment arrangements.
3. Unaccompanied Minors - Parents (or guardians) are responsible for co-payments, deductibles, and non-covered amounts at each visit.
4. If you are more than 10 minutes late to your scheduled time, then you may be asked to reschedule your appointment.
5. We respectfully ask you to give us as much notice as possible. Unless an appointment is cancelled at least 24 hours in advance, you may be subject to a $30 fee.
6. Overpayments will be refunded to the responsible party within 30 days upon written request.
7. I agree to pay $35 for any returned checks in addition to the amount of the check that have been returned within 5 days of the check being returned.

Assignment of Benefits/Medical Release: I authorize TRUE Physical Therapy P.A. to accept payments of medical benefits for the services they provide. I understand that I am responsible for any amount not covered by insurance and it is my responsibility to know my copays, deductibles, out of pocket amounts, etc., which have been established through my individual insurance policy. I authorize release of any medical information necessary to process this claim and all future claims.

Signature_____Date _____