Physical Therapy Services Consent Form

Name: _____

Date: _____

Acknowledgment of Services

Services may include assessment, therapeutic exercise, manual therapy, stretching, mobility training, and education for wellness and injury prevention.

Medical Clearance

I confirm that I have chosen to participate voluntarily, understanding the risks involved.

I understand that it is my responsibility to inform the therapist of any relevant medical conditions, injuries, surgeries, or changes in my health status before each session.

Assumption of Risk

I acknowledge that participation in physical therapy or exercise carries potential risks, including but not limited to muscle soreness, strain, falls, or other injuries.

Informed Consent

I understand the nature and purpose of the proposed services and have had the opportunity to ask questions. I consent to receive physical therapy services as determined appropriate by the therapist.

Client Acknowledgment

By signing below, I confirm that I have read, understood, and voluntarily agree to the above terms.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email or texting communication.
- ☐ I consent to receiving communication about the **scheduling of appointments** (limiting the information disclosed) by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail
- ☐ I consent to all communication, including but not limited to **communication about my medical condition and advice from my health care providers** by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail

E-mail address:

Phone number:

- ☐ **I have been given the opportunity to read and obtain a copy of the Privacy Practices Statement.**

Client Acknowledgment

By signing below, I confirm that I have read, understood, and voluntarily agree to the above terms.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Health History

Are you currently taking any medications? If yes, list below:

_____

_____

Do you have any of the following health conditions? (circle all that apply)

Arthritis (list type here):_____

History of blood clots (list date here):_____

History of stroke (list date here):_____

Heart failure

Other heart condition (list here):_____

Surgery in the past 5 years (list type and date here):_____

History of cancer (list type and date here):_____

Bruise easily

Chronic pain (explain here):_____

Skin conditions (list here):_____

TMJ disorder

Headaches (list frequency): _____

Migraine (list frequency): _____

Scoliosis

Neurological condition: _____

Other (list here):_____

Allergies (list here):_____

I acknowledge the importance of informing my physical therapist of all relevant medical conditions and medications I am currently taking, and I will notify the therapist of any changes to these conditions.

Patient Signature: _____ **Date:** _____

Physical Therapy Payment Agreement

Thank you for choosing Lydia Gruben as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Use of Health Savings Accounts (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** We accept payment from these accounts for medically necessary services, such as physical therapy. If you are purchasing wellness or massage therapy services, consult the IRS guidelines and your plan rules to determine whether your services qualify for payment from an HSA, HRA or FSA account.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) We are out-of-network with all health plans. If you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You understand that even if you have out of network benefits, you may be required to pay a higher copay or coinsurance for out of network services and you may have separate out of network deductibles and out of pocket maximums. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Medicare Policy (for Medicare Part B and Medicare Advantage Plans).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are ***not*** enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and some of the services we offer are not covered by Medicare. Since we are not enrolled providers, we cannot submit claims to Medicare ***and*** Medicare will not pay for our services even though the same services might be paid by Medicare if you obtain them from a Medicare enrolled provider. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. As a condition of us providing services to you, you are choosing, of your own free will, not to use your Medicare benefits and are agreeing to pay privately at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf and agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement.
    - **Medicare supplemental plans.** Medicare supplemental plans will not reimburse you for our services because we are not enrolled providers with Medicare. Therefore, you should not choose to see us if you are expecting to be reimbursed by your supplemental plan.
    - **Medicare as primary payer, Commercial Plan as secondary payer.** If you have a commercial health plan as a secondary payer, you will not likely be able to use it because the commercial plan will probably require you to submit claims to Medicare first or obtain a Medicare denial. We cannot submit claims to Medicare just to get a denial.
    - **Commercial Plan as primary payer, Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement of copays, coinsurance or deductibles that your commercial health plan does not pay.
- **Wellness & Fitness Services.** Most commercial health plans and Medicare do not cover the wellness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages and Refund Policy.** If you purchase a discount package of services, the package discount is applied at the end of the package. You should use your visits within 12 months. If you request a refund for the unused visits, we will calculate your refund by applying our full visit fee to the visits you used. You do not qualify for the package

discount if you do not use all the visits in the package. If you paid with an HSA, HRA or FSA debit card, we will refund the card you paid with. You are responsible making sure you comply with the rules of your plan when paying for services or receiving a refund.

- **Cancellation Policy.** We require a 24-hour notice to cancel a scheduled appointment. If you cancel with less notice, you will be required to pay for 100% of the service. We reserve the right to waive this policy at our sole discretion..
- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **Service Termination Policy.** If we determine at any time that conditions create a potentially unsafe environment for our providers, we may, at our sole discretion, terminate our services with you. If we do so, we will make reasonable efforts to refer you to the services you need to resolve the issue that is causing a potentially unsafe environment. If you have prepaid for any services, we will refund any monies paid for services not yet received as of the date of our termination.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

I acknowledge that I have chosen, of my own free will, to obtain the services provided by Lydia Gruben, PT, DPT, LMT and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

Patient Name (Print or Type): _____

X _____ Date: _____

Patient's Signature