
PRIVACY PRACTICES ACKNOWLEDGEMENT

Physical Therapy Advantage
35 S. Randall Road
North Aurora, IL 60542
(630) 892-8003

I have received and have been presented with the opportunity to review the Physical Therapy Advantage Notice of Privacy Practices.

Patient/Spouse/Legal Guardian

Date

Patient Declined Copy: _____ Patient Declined to Sign: _____ Employee initials (if patient did not accept): _____

CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment at Physical Therapy Advantage, that I authorize and consent to the administration and performance of physical therapy treatments which may be provided by a physical therapist or other members of the Physical Therapy Advantage staff. Minors must be accompanied by a parent/legal guardian for medical care.

Patient/Spouse/Legal Guardian

Date

Witness

Date

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to Physical Therapy Advantage for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to insurer or agency shown. In Medicare assigned cases, Physical Therapy Advantage agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. **I authorize the use of this signature on all insurance submissions.** (This includes both claims and complaints.) This order will remain in effect until revoked by me in writing.

Patient/Spouse/Legal Guardian

Date

NON-MEDICARE ASSIGNMENT & RELEASE

I, the undersigned, certify that I have insurance coverage and assign directly to Physical Therapy Advantage all physical therapy insurance benefits. A photocopy of the original is to be considered as valid as the original. I understand that I am financially responsible for all charges incurred for services rendered to me and I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I hereby authorize Physical Therapy Advantage the release of information necessary to file a claim with my insurance company or Workmen's Compensation carrier. **I authorize the use of this signature on all insurance submissions.** (This includes both claims and complaints. This order will remain in effect until revoked by me in writing.

Patient/Spouse/Legal Guardian

Date

PHONE AUTHORIZATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Rank # _____

_____ **Home Telephone** _____

- O.K. to leave message w/ detailed information
 Leave message with call-back number only

Written Communication

- O.K. to **mail** to my **home** address

_____ **Work Telephone** _____

- O.K. to leave message with detailed information
 Leave message with call-back number only

_____ **Cellular Telephone** _____

- O.K. to leave message with detailed information
 Leave message with call-back number only

In completing and signing this form, I authorize that Physical Therapy Advantage may leave a message containing medical information for a period of 12 months from the date signed on the form.

If you would like to change any of the information on this form, prior to the end of the time period stated above, you must contact Physical Therapy Advantage in writing and request the change. This form must be up to date, signed and on file in your chart prior to any medical information being left on an answering machine or with individuals you designate.

Patient/Spouse/Legal Guardian

Date

Witness

Date

EMAIL AND TEXT REMINDERS

Please indicate if you would like appointment reminders as indicated below:

text reminder before appointments: ___yes ___no (cell phone # _____)

Receive email reminder: ___yes ___no

Receive quarterly newsletter via email: ___yes ___no

Your email address: _____

ATTENDANCE POLICY

LATE ARRIVALS . If a patient is more than 15 minutes late for an appointment it is the therapist's discretion as to whether or not the patient will be seen or need to be rescheduled.

CANCELLATIONS . We request a minimum of 24 hours notice.

NO-SHOWS . A \$25.00 fee will be assessed for each no-show. A patient will be discharged upon three no-shows for routine visits. The referring physician and/or caseworker (if applicable) will be notified.
