FAIRFAX FAMILY PHYSICAL THERAPY, P.C.

1282 Main Street, Fairfax, Vermont, VT. 05454 – 802-849-9308 Krystal Jenness

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Fairfax Family Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my/my Childs' physical condition.

I also acknowledge my rights to protected health information under the HIPAA act and have been offered a copy of the Notice of Privacy Act.

Benefit of Assignment/Release of Information

I hereby assign all physical therapy benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to **Fairfax Family Physical Therapy.** A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Financial Policy Statement

It is your responsibility to know and understand your insurance company's coverage for therapy, deductibles, co-pay or Durable Medical Equipment such as braces and orthotics.

As a courtesy, we will bill the insurance carrier(s). You are responsible for the entire bill when the services are rendered. We require that payments of your estimated share be made today for any deductible, co-insurance, or co-payment amounts. Not all services are covered in all insurance contracts. If your insurance company requires a referral and/or prior authorization, contact your primary care physician prior to seeing a specialist. If your insurance carrier does not cover a service or procedure or remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

Please be advised if we file your claim through Worker's Compensation or Auto Medpay and your claims are subsequently denied, you will be held responsible for the total amount of charges for services rendered to you.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Fairfax Family Physical Therapy.

It is your responsibility to notify us if your insurance carrier and/or coverage changes and to understand your new insurance plan benefits.

To find out what your insurance plan covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

It is your responsibility to know your insurance company's patient responsibilities and procedures. If you do not follow your insurance company rules you may be liable for full payment of the bill.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. **I understand my responsibility for the payment of my account and I understand the cancellation/no show policy outlined on the back of this form and agree to the fees associated with cancellation less than 24 hours and failure to show for my appointment.**

_____ _____

Patient/Guardian/Responsible Party **Date**

_____ _____

Witness **Date**

Medicare Patients Only

Medicare requires that you see your physician every 90 days while you are receiving physical therapy services or they may not cover the costs associated with your therapy visits. I acknowledge an understanding of this policy and my responsibilities associated with it.

_____ _____

Patient/Guardian/Responsible Party **Date**

Cancellation and No-Show Policy

The following are policies regarding cancellations and no-shows. We take this subject seriously at this clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatments. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

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 get the full treatment for that week. In some cases, this may not work.

We reserve the right to charge $35.00 for a cancellation without proper notice or if you fail to show up for an appointment. This charge will not be covered by insurance but will have to be paid by you personally. In the event of a no-show you must contact us by the end of that business day to confirm upcoming appointments or they will be removed from our schedule.

You may need to be seen by a different therapist than the one that normally treats you if you rearrange your appointment. All our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands.

Please understand that your pain will probably increase and decrease as your course of treatment progresses and before you are finally released. Either condition can seem like a reason not to come in; a) you're feeling worse and you feel treatment is not working, b) you're feeling better and it's a great day to go shopping or to sporting events. Neither of these conditions is legitimate as a reason not to come:

a) If you are in pain, come in and get it fixed.
b) If you are out of pain, now is the time that we can begin doing some real correction of underlying causes of your problem or educate you so, you will not re-injure yourself.

When a patient doesn't show as scheduled, three people are hurt:

1) You, because you won't get the treatment you need as prescribed by the doctor or PT.
2) The therapist, who now has a space in their schedule since the time was reserved for you personally.
3) Another patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard and we will have you out of pain and back to full function as swiftly as possible. We're looking forward to working with you.

Patient signature_____Date_____