

# Consent for Treatment



I voluntarily consent to care which may include routine treatment by a physical therapist, his/her designees, as necessary in his/her judgment. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as the result of service, procedures, treatments or examinations at Crossroads Physical Therapy, llp.

## USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my health care, Crossroads Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

## PAYMENT

I request that payment of authorized Medicare/insurance benefits be made either to me, or on my behalf to Crossroads Physical Therapy, llp. for any services furnished by this provider employed by the same. I authorize any holder of medical information about me to release to my Medicare/insurance carrier, and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand that as a service, Crossroads Physical Therapy will submit all claims to Medicare/my insurance company and that on occasion these institutions will decide not to pay unless I receive services. Therefore, I may be billed for items or services and may have to pay the bill while Medicare/my insurance company denies payment. I agree to be personally and fully responsible for payment. That is, I personally will pay, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare’s decision. Payment can be made at any time to our office. You may pay your co-pay at the time of service. If your insurance requires a primary care referral, it is your responsibility to obtain this. If you do not obtain a referral and your insurance company requires this you will be responsible for payment.

## CANCELLATION AND NO SHOW POLICY

I understand that by signing the consent for treatment, I have received, read and understand Crossroads Physical Therapy’s cancellation and no show policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*If you are 18 years of age or younger, a parent or guardian must sign this form on your behalf.*

## MEDICARE PATIENTS

As a Medicare patient I have received and understand my responsibilities in regards to seeing my referring physician and obtaining new orders.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Thank you for assisting us with your care.*