FISHER PHYSICAL THERAPY

Patient Name: _____ **DOB**: _____ **Date:** _____

General Information

Thank you for choosing Fisher Physical Therapy. It is our goal to provide you with a high quality rehabilitation treatment plan individualized to meet your specific needs. So that we have a mutual understanding concerning your treatment, we ask that you review the following information prior to starting your program. **Our cancellation policy states that we require 24 hours' notice to cancel your appointment. If less than 24 hours' notice is given a $30 cancellation fee will be issued for scheduled treatments, $75 for initial evaluation.**

Appointments: Typically, appointments will be scheduled with your therapist 1 to 3 times per week. We ask that you make every effort to keep appointments and to arrive by your scheduled time. If you arrive more than five minutes late for an appointment we cannot guarantee that you will be seen that day. Please help us to serve you (and all of our patients) better by keeping scheduled appointments.

Clothing: Please wear loose and comfortable clothing for each session, we have changing rooms for your convenience.

Fees:
$30 nonsufficient funds check fee

Payment: You are responsible for all payment of services rendered by Fisher Physical Therapy whether your insurance company pays or not. Although we will do our utmost to assist in gathering information regarding claims payment, it is your responsibility to know your benefit and coverage limits as well as which services require authorization. Please note your insurance contract is between you and the insurance company; we are not a party to that contract. Our relationship is with you and not your insurance company. Payment due at the time of service for copays, deductibles, services deemed non-covered by your insurer and any other items addressed herein. Budget payments are available on an individual consideration basis. We accept cash, check, credit cards, and money orders.

Rules for Plans of Nonparticipation: We will provide the service of submitting claims to your insurer if we are nonparticipating; however, if payment is not received within 90 days from the date of service, the bill then becomes your financial responsibility. You are responsible for our entire charge less any payment from your insurer. If we do not participate with your secondary (or any non-primary) insurer, you are responsible for that portion of your bill at the time of service.

If at any time you have any questions about your treatment program, please bring your concerns to the attention of your therapist. Also, our office staff is available to answer any questions regarding insurance, scheduling and to assist you in any way that will make your participation in your program here more convenient and worthwhile.

IN SIGNING THIS POLICY…
You assign your insurance benefits directly to Fisher Physical Therapy, and you authorize Fisher Physical Therapy to release any medical information necessary for clinical or claims payment purposes, you certify all information given is correct to the best of your knowledge, you agree to release all treatment records upon request. If you do not wish to release your medical records for any reason, please indicate below. Your signature on this document serves as a "signature on file" for all claims submitted to your insurance company for services rendered.

☐ I request the following restriction to the use or disclosure of my health information

_____

_____

☐ The practice will not disclose patient information (This includes discussions for treatment, RX renewals, details of appointments and billing problems among other information) to anyone other than the people listed on the lines below. You must specify each person including non-custodial parents, spouses, guardians and other family members.

IF NO NAMES ARE GIVEN, NO PATIENT INFORMATION WILL BE DISCUSSED WITH ANYONE OTHER THAN THE PATIENT.

Names: _____

_____

Again, thank you for choosing Fisher Physical Therapy. We look forward to working together toward achieving your rehabilitation treatment goals.

Patient Name: _____ **DOB**: _____ **Date:** _____

Consent for Specific Treatments

In physical therapy, the therapist may need to work on certain muscles in sensitive areas such as the groin, chest, and buttock areas depending upon the diagnosis you are being treating for. During your treatment session a therapist will always ask permission to treat these areas as well as to explain the rational for the treatment. As a patient you have the right to refuse any treatment that may make you feel uncomfortable. If this was to occur, please let your therapist know and he or she will stop treatment immediately. Fisher Physical Therapy appreciates your business and wants your time with us to be a therapeutic and professional experience.

Fisher Physical Therapy's Cancellation Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.
Your adherence to the recommended number of treatments is a vital component of your progress. Therefore we have certain rules that need to be followed in order to ensure the most optimum results.

Please read and initial the following:

1. _____ **NO-SHOW**: When a patient is scheduled for an appointment and does not call into cancel nor shows up for the appointment a **$30.00 fee will be charged**.

2. _____ **CANCEL WITHOUT 24 HOUR NOTICE**: When a patient is scheduled for an appointment and calls to cancel but does not give the clinic 24 hours' notice and does not reschedule for the **same week** a **$30.00 fee will be charged**.

3. _____**CANCEL WITH 24 HOUR NOTICE OR MORE**: We will reschedule make up appointment as soon as possible.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Notice of Privacy Practices and Patient Acknowledgment Form

Fisher Physical Therapy is required by a federal law known as "The Health Insurance Portability and Accountability Act" (HIPAA) as well as by Texas state law to maintain the privacy of your medical and health information; also referred to as "Protected Health Information" (PHI).

Our notice of Privacy Rights and Practices describes how information about you may be used and disclosed and how you may obtain access to this information. This notice is available on our webpage FisherPT.net. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the notice (or any other Notice in effect at the time of the use of the disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree with this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your signature below constitutes your acknowledgement that you have received a copy of our Notice of Privacy Rights and Practices, and your consent under federal and state laws to the kinds of uses and disclosures of Protected Health Information mentioned in our Notice.

Authorization for Patient Release of Information

I the undersigned, hereby authorize Fisher Physical Therapy to release my Protected Health Information (PHI). I have reviewed a copy of the Fisher Physical Therapy Notice of Privacy Rights and Practices and I understand that Fisher Physical Therapy will only disclose the minimum information necessary for my treatment and payment of my services according to the Health Insurance Portability and Accountability Act (HIPPA/US. Department of Justice 5 U.S. C 552a (b) regulating protected health information (PHI).

I understand that I have the right to limit the kind of information released. I further understand that I have the right to revoke this consent at any time by written request to my provider.

"The Undersigned" hereby acknowledges that he/she has reviewed all the terms and conditions on both sides/pages of this form and agree to the same.

_____	_____	_____
Patient Signature	Patient Printed Name	Date
_____	_____	_____
Personal Representative or Guardian Signature	Relationship to Patient	Date