SPINESCOTTSDALE PHYSICAL THERAPY

Moving in the Right Direction

PATIENT CONSENT FORM

Consent for Evaluation, Care, and Treatment

I consent to physical therapy services at SpineScottsdale Physical Therapy, including an initial evaluation and course of treatment. I understand that I am responsible to inform the physical therapist of any health problems and allergies I have, as well as any drugs or medications I am taking.

Assignment of Benefits

I authorize payment of my insurance benefits to be made directly to SpineScottsdale. I further authorize the release of my information, including medical records, to secure payment.

Waiver, Release, and Assumption of Risk

This form is an important legal document. It explains the risks you are assuming by beginning physical therapy at SpineScottsdale, Inc. It is critical that you read and understand it completely. After you have done so, please print your name legibly and sign in the spaces provided at the bottom.

Waiver, Informed Consent, and Covenant Not to Sue

I have volunteered to participate in a program of physical therapy under the direction of SpineScottsdale, Inc., which may include, but may not be limited to, modalities (Electrical Stimulation, Ultrasound, Moist Heat Pack, Cold Pack, TENS unit), manual therapy (Joint Mobilization, Massage, Traction, Soft Tissue Mobilization, Stretching, Passive Range of Motion, Active Range of Motion), Vibration Therapy on VibePlate, BioDex Balance System, Marodyne Vibration Plate, and therapeutic exercise (Core/Trunk Stabilization, therapeutic exercise/conditioning, gait training, body mechanics education, ergonomics education, balance training, education on home exercise program, weight and/or resistance exercise, cardiovascular exercise, and flexibility exercise). In consideration of SpineScottsdale, Inc. agreement to instruct, assist, and train me, I do here and forever release and discharge and hereby hold harmless SpineScottsdale, Inc. and its respective agents, heirs, assigns, contractors, and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in this or any exercise program including any injuries resulting, other than those due to undue negligence by SpineScottsdale, Inc. and its representatives. This waiver and release of liability includes, without limitation, injuries which may occur as a results of (1) Equipment that may malfunction or break when prior warning was given (2) any slip, fall, dropping of equipment, and (3) injury due to patient negligence in following instruction of supervision.

Assumption of Risk

I recognize that physical therapy might be difficult and strenuous and that there could be dangers inherent in physical therapy for some individuals. I acknowledge that the possibility of certain unusual physical changes during physical therapy does exist. These changes include abnormal blood pressure; fainting; disorders in heartbeat; heart attack; and, in rare instances, death. I understand that as a result of my participation in a physical therapy program, I could suffer an injury or physical disorder that could result in my becoming partially or totally disabled and incapable of performing any gainful employment or having a normal social life. I acknowledge and agree that I assume the risks associated with any and all activities and/ or exercises in which I participate in at SpineScottsdale, Inc. I acknowledge and agree that no warranties or representations have been made to me regarding the results I will achieve from this program. I understand that results are individual and may vary.

I acknowledge that I have thoroughly read this waiver and release and fully understand that it is a release of liability. By signing this document, I am waiving any right I or my successors might have to bring a legal action or assert a claim against SpineScottsdale for any injury sustained that is not due to negligence of its employees, agents, or contractors.

I understand and agree to the statements above.

Patient Signature _____ Printed Name _____ Date _____

Signature of Guarantor (If different from patient) _____ Printed Name _____ Date _____

10277 N. 92nd St. Suite 103 Scottsdale, Arizona 85258
Phone (480) 584-3334 Fax (480) 272-9369
www.spinescottsdale.com

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PATIENT INFORMATION ACKNOWLEDGEMENT

As part of my health care, SpineScottsdale, PLLC creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results, and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among SpineScottsdale's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for SpineScottsdale that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that SpineScottsdale may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment, or other healthcare operations and that SpineScottsdale, PLLC is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of SpineScottsdale, PLLC, and agree to the liability limitations explained therein.

_____

Signature of patient or legal representative Date Relationship to Patient

_____

Printed name of patient

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CANCELLATION / NO SHOW POLICY

- I understand that if I fail to attend a scheduled appointment or cancel an appointment less than 24 hours before my appointment time, I will be responsible for a $50 no show/cancellation fee if I do not reschedule. This fee is not reimbursable by insurance.
- I understand that the $50 no show/cancellation fee will be waived if I call to reschedule my appointment.
- It is my responsibility to know when my appointment is, regardless of whether or not I received a reminder from SpineScottsdale.
- If I am more than 15 minutes late for my appointment, SpineScottsdale reserves the right to reschedule my appointment.

By signing below I understand and agree to the statement above.

_____

Patient Signature Patient Printed Name Date

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees: (If authorized, please include your **PCP**. Minors please include **all** authorized **parent/ guardian** names)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____

Patient Signature Printed Name Date

_____

Signature of Legal Guardian (If patient is a minor) Printed Name Date

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PATIENT FINANCIAL POLICY

Copayments, Coinsurance, and Deductibles:
I understand that I am responsible for payment of all covered and non-covered services, which includes copays, deductibles, and coinsurances. This agreement is part of my contract with my health insurance company. Failure to pay my balance may be considered a breach of contract with my health insurance company. SpineScottsdale will bill the insurance company first, as a courtesy to its patients. I am responsible for any balance unpaid by my insurance company upon receipt of a statement from SpineScottsdale.

_____
(Initials)

Payment at Time of Service
I understand that payment will be collected **before** services are provided. I understand if I'm unable to make my payment my appointment will be rescheduled.

_____
(Initials)

Know Your Benefits
Each and every insurance company and plan, including Medicare, has different plans, each with different benefits. Your health insurance coverage is a contract between you and your insurance company. SpineScottsdale Physical Therapy is not part of this contract. You are responsible for understanding your insurance policy and benefits under your plan. Your insurance company can assist you with any questions you have relative to your own benefits with them. Therefore, SpineScottsdale Physical Therapy cannot be held responsible for informing patients of their benefits as outlined in your plan documents.

_____
(Initials)

Verification of Benefits
As a courtesy, SpineScottsdale will contact your insurance company and verify your insurance eligibility and benefits. I understand that this verification does not guarantee coverage and may be subject to errors. We recommend you contact your insurance company to verify your insurance eligibility and benefits.

_____
(Initials)

Payment of Bills
I understand that I am responsible for the balance after my insurance company processes the claim. If I feel there has been an error, I agree to pay the balance due to SpineScottsdale while I make inquiries to my insurance company. If a correction is made in my favor, SpineScottsdale will reimburse my overpayment.

The insurance process may take several months to process your claim. In the event that your insurance company does not pay your claim, we will transfer the remaining balance to you and we will send you a statement. If the account is not paid in full by the due date on the statement, then the unpaid balance will be turned over to a collection agency. You will be responsible for an additional 35% of collection fees and/or legal fees in addition to the remaining balance.

I understand that it is my responsibility to notify SpineScottsdale of any address, phone number, and insurance changes, and in the case that SpineScottsdale is unable to contact me, any outstanding balance will be referred to a collection agency.

_____
(Initials)

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Medical Records Requests
SpineScottsdale Physical Therapy will charge me $15 and require a signed medical release form to release medical records. I further understand that a request for my records must be submitted in writing and records will not be provided until payment for the medical records fee has been made in full.

_____
(Initials)

Additional Fees
A $30.00 fee will be charged on every account closed, stop payment, non-sufficient funds, or returned checks

_____
(Initials)

What Insurance Do You Want Us to Bill?
I am asking SpineScottsdale to bill according to the option indicated below for services rendered, and understand that this decision is final, and may only be changed in the event of exhaustion or termination of benefits. If this injury is the result of an auto accident or other accident involving a third party, I understand I have several different billing options. If I had an injury at work, I understand that my personal insurance will not cover the expenses. I have chosen below which type of insurance policy to charge.

_____
(Initials)

- ❑ Personal Insurance (Includes Medicare)
- ❑ Worker's Compensation
- ❑ Self Pay
- ❑ My auto policy- MedPay/ PIP
- ❑ Lien-Third Party Auto Policy

Thank you for your understanding of our financial policies at SpineScottsdale Physical Therapy. If you have any questions, please contact our billing department at: billing@spinescottsdale.com

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I have read and agree to the above financial policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

_____

Patient Signature Printed Name Date

_____

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