CONDITIONS & CONSENT FOR PHYSICAL THERAPY SERVICES

I understand that I am a patient of TITAN Physical Therapy LLC, a private, therapist owned Physical Therapy practice. Cooperation with treatment in order for Physical Therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home Physical Therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my Therapy Team.

Cancellation Policy: I understand that to successfully achieve the goals of treatment established by myself and my physical therapist it is essential for consistent attendance as outlined by my plan of care. I understand that two (2) no shows could result in my discharge from therapy. Furthermore, I understand that if I cancel more than 24 hours in advance I will not be charged. I understand that if I cancel in less than 24 hours in advance, I will pay a cancellation fee of $25.00. To be paid at the time of my next appointment.

Limitations: I understand that there are no guarantees regarding a cure for, or improvement in my condition. I understand that my Physical Therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. There may be times where my insurance company will withhold payment for certain services rendered but care will be taken to inform me of such circumstances prior to rendered services.

Informed Consent for Treatment: I understand the term informed consent means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential Risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential Benefits: I understand I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I can expect to gain a greater knowledge about managing my condition and the resources available to me.

Financial and Insurance Responsibilities: I understand it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization that is necessary, and to obtain verification of my outpatient physical therapy benefits. I understand TITAN Physical Therapy LLC will call my insurance carrier as a courtesy for me but ultimately it is my responsibility to verify the information TITAN Physical Therapy LLC receives is accurate. If I have any questions regarding my insurance coverage I understand that I can ask my insurance carrier, my therapist, or TITAN Physical Therapy LLC for further assistance.

Authorization of Payment: I hereby assign my insurance benefits to be paid directly to TITAN Physical Therapy LLC. I understand that I am financially responsible for all non-covered services, co-pays, deductibles and/or coinsurance, and that insurance coverage is not a guarantee of benefits/payment. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I understand the privacy

practices (HIPAA) and how my personal health information can be used. I authorize TITAN Physical Therapy LLC to release any medical information required to process any claim. I authorize TITAN Physical Therapy LLC to contact me by telephone/email to remind me of my appointments. I authorize TITAN Physical Therapy LLC access to my electronic medical history.

Notice of Privacy Policies: I understand that I was provided with a copy of the Notice of Privacy Policies utilized by TITAN Physical Therapy LLC in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) Sec. 45 CFR 160 and 164.

I fully understand that in the event my insurance company or financially responsible party does not pay for services I receive, I will be financially responsible for payment. To avoid being held financially responsible for claims due to exhaustion of benefits, it is highly recommended that you keep track of your therapy visits throughout the year. It is also important that you let your insurance company know of your discharge from other therapy programs to avoid denial of coverage based on concurrent treatment.

Please initial:

_____ TITAN Physical Therapy LLC, and their representatives, did not place any pre-retention phone calls to me or my family or undertake any in person face-to-face solicitation to be treated by the medical provider or their associates. I have visited TITAN Physical Therapy LLC, of my own free will, without duress, concern, or promises of cash payment, or special treatment beyond good, hard work and diligent medical representation. I recognize there are many other health care providers available to handle my illness but choose TITAN Physical Therapy LLC, and their associates to do so.

____I understand that my therapist will develop an individualized Plan of Care for me of which I will be expected to complete exercises, stretching, light cardio, manual therapy, etc. In order to implement this Plan of Care, I understand I will be working with and receiving instruction from therapy technicians, therapy assistants, and therapists. I agree to cooperate with the entire therapy team and adhere to my plan of care.

____I understand TITAN Physical Therapy is a family place of health and wellness. I agree to refrain from any inappropriate or disruptive language, attitude, or behavior that might upset or offend other individuals present. This includes but is not limited to disruptive cell phone use, vaping, inappropriate language, strong odors, refusal to cooperate with therapy team, etc. I understand that if another individual complains or comments about any of my behaviors or language I may be asked to discontinue and/or modify such behaviors.

I have read the above information and I consent to the Physical Therapy Evaluation and all subsequent treatment. I understand if I do not adhere to the office policies outlined in this consent form I may be discharged from therapy.

_____ _____

Patient Name (Please Print) **Date**

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Patient Signature (or Legal Guardian/Witness)

DISCHARGE POLICY

A decision to discharge a patient will be based upon any of the following reasons:

- Patient achieves all therapeutic goals established by therapy team, patient, family, and/or caregiver
- Patient requests discharge and/or transition
- Therapy services no longer produce a functional/measurable outcome for the patient
- Patient is unable to progress toward anticipated goals and/or expected outcomes because of medical/psychosocial complications
- Patient fails to progress or retain acquired progress due to failure to uphold attendance as prescribed
- Patient no call, no shows for two (2) or more appointments
- Patient is unable to be reached despite efforts (ie: phone calls, letter, email)
- Patient refuses to attempt and/or complete all exercises as outlined in individualized plan of care
- Patient is unable to attempt and/or complete all exercises as outlined in individualized plan of care
- Patient refuses to take direction and/or cooperate with staff, including but not limited to front desk, physical therapy technicians, and other licensed clinicians
- Patient engages in any inappropriate or disruptive language, attitude, or behavior that might upset or offend other individuals present
- Patient is disrespectful to staff or others present in any way
- Patient does not adhere to No Cell Phone Use Policy use while present in therapy

I have read the above information and I understand Back to You Physical Therapy's discharge policy.

_____ _____

Patient Name (Please Print) **Date**

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Patient Signature (or Legal Guardian/Witness)