V.03102020

PTcares PHYSIOTHERAPY PATIENT CONSENT FORM

Patient contact info

First Name:	Last name:	
Home address:	Email address:	
City:	State:	Zip code:
Home phone:	Cell phone:	Work phone:
Date of Birth:	Date of injury:	
Emergency Contact: Name:	Relationship:	Phone:

Release of Information

I, _____give PTcares Physiotherapy and Wellness LLC my consent to release/ obtain /share information from/to insurance, PCP and the following individuals with respect to my care:

Physician(s): _____ Phone: _____ Initials:_____
Fax: _____

Others: _____ Phone: _____ Initials:_____
Fax: _____

Consent for Assessment and Treatment

Physiotherapy treatment techniques may include but are not limited to manual techniques, spinal manipulation, electrotherapeutic modalities, acupuncture, and exercise. These may be recommended during your program. It is the policy of PTcares Physiotherapy to ensure that the benefits, side effects, and potential complications of each chosen modality above are explained to you. Throughout the program, should you have concerns or questions about any recommended treatment, you must inform the therapist immediately so the rationale for treatment and/or adjustments to your treatment can be made. It is your responsibility to participate in all aspects of the program as it is imperative to its success. If you choose not to participate, you must inform your therapist immediately. Payments will be collected at the time of service. PTcares Physiotherapy offers FREE phone, email, text and 20 mins discovery face to face consultation with same policies applied. I understand and agree with the above policy. I agree to participate in an assessment and treatment program delineated by PTcares Physiotherapy and Wellness LLC. I understand that I can withdraw my consent at any time.

_____ _____
Signature (If under 16, guardian must sign) **Date**

_____ _____
Dr. Sheng Wu PT.DPT **Date**

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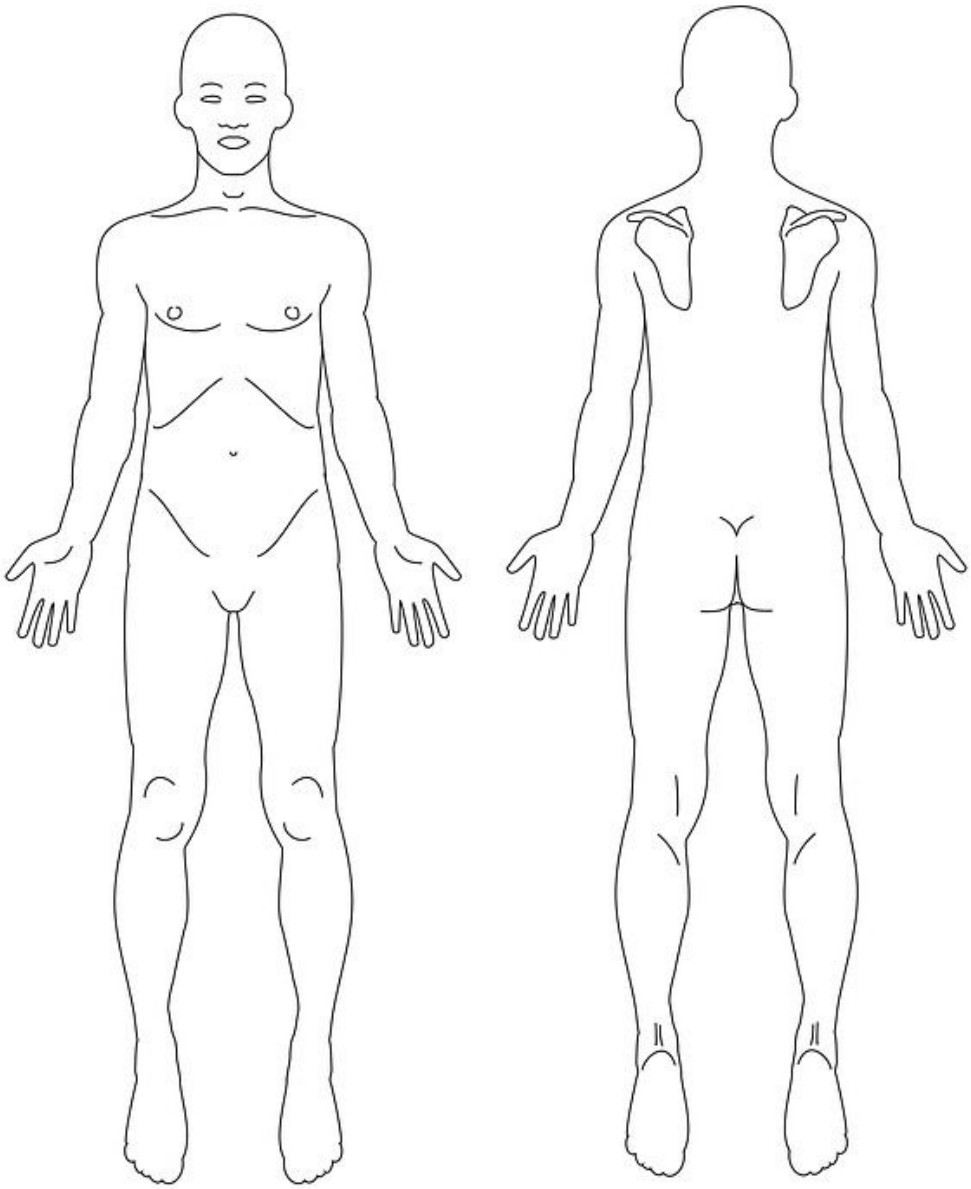
Tell us about your Health

1.What are your goals?

_____

2.Mark below your irritation location



3. Rate the pain from 0-10: 0 1 2 3 4 5 6 7 8 9 10

Handedness: Right Left

4. Do you have other health problems?

Heart	**Bowel trouble**	**Metal Implants**
Arthritis	**Bladder trouble**	**Seizures**
Depression	**Pacemaker**	**Kidney disease**
Broken bones	**Recent weight loss**	**Cancer**
HIV	**Stroke**	**Tuberculosis**
Multiple Sclerosis	**Diabetes**	**Osteoporosis**
High Blood pressure	**Breathing problems**	**Hepatitis**
Asthma	**Allergies**	**Pregnant**
		Thyroid problems

5. List any surgeries you have had: _____

6. Before you come to our clinic, Did you try other treatment options?

MD	**Chiropractor**	**Other PT clinic**
Injection	**Traction**	**Pain meds**
Acupuncture	**Massage**	**_____**

7. Are you planning to lose weight by exercises and/or diet?

☐ **Yes** ☐ **No**

8. Do you want to receive educational newsletter and update of current evidence of research articles related to your condition by email?

☐ **Yes** ☐ **No**

_____ _____

Patient Sign Here **Date**

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Reschedule, Cancellation and Refund Policies

Reschedule and Cancellation Policies

PTcares Physiotherapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience by providing a flexible plan of care and meeting in your home or office or gym.

Your consistent attendance of the planned treatment regimen is paramount to your full recovery. While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

If you are more than **30** minutes late for your appointment and fail to notify us, treatment may be cancelled and a 20 dollars fee charged for missing the appointment. A scheduled appointment MUST BE CANCELLED AT LEAST **6** HOURS IN ADVANCE or a 20 dollars fee will be charged for that appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR. No cancellation fee will be charged if the missed appointment is made up within the next 7 days when it was scheduled on a day that you do not have another appointment scheduled. We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of the staff at PTcares Physiotherapy appreciates your anticipated adherence and cooperation with this policy. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

_____ ____ / ____ / ____

Patient Acknowledgement/Signature Date

Refund Policies

At PTcares Physiotherapy we believe our service will provide valuable benefits for you to achieve your ultimate goals. We want to be **YOUR** personal physical therapist for now and future.Just like how you use “My” in front your Hairdresser, dentist, and family doctor, we want you to call us as “**My** physical therapist(s)”.

Your experience with our service is very important to us. Based on your specific medical condition(s), we recommended a discussion of your progression **every 3 weeks**.

We offer 100% worry-free guarantee refund policy:

If you absolutely do not benefit from PTcares personal PT service, you can request a REFUND with 100% guarantee!

Refund will be applied to PT copay fees within 21 days after the day of the service.

_____ ____ / ____ / ____

Patient Acknowledgement/Signature Date

PTCARES PHYSIOTHERAPY AND WELLNESS LLC

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.

- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRECTLY TO THE PROVIDER(S).

_____ _____

Signature of patient/Reasonable party **Date**