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Physical Therapy Services Policies and Procedures

Welcome! Thank you for choosing Fast Track Physio, PLLC ("Fast Track") for your physical therapy treatment. We provide comprehensive physical therapy through direct one-on-one hands on care. You'll receive a customized, highly skilled plan of care addressing neuromusculoskeletal components to correct dysfunction, improve soft tissue mobility, optimize movement, and promote intrinsic motivation and independent self-management techniques.

Please carefully review, initial, and sign these policies and procedures. They set forth the terms of our relationship as you receive physical therapy from Fast Track.

About You

Name: _____

Preferred name (if different): _____

Date of birth: _____/_____/_____ Sex: _____ Relationship status: _____

Mailing address: _____

Your Emergency Contact	*Your Primary Care Provider*
Name: _____	Name: _____
Phone number: _____	Phone number: _____
Relationship: _____	City/state: _____

Communication Preferences + Policy

Please tell us below how we should communicate with you. Please note: If you request email or text communications, or if you contact us by email or text message, you indicate your consent to receive *unencrypted* emails and text messages from us, which may not be secure.

● Please fill in the bubble for your preferred communication method below.

○ Email:			
○ Cell phone:	Can we leave a voicemail?	Yes ☐	No ☐
	Can we send a text message?	Yes ☐	No ☐
○ Other phone:	Can we leave a voicemail?	Yes ☐	No ☐
	Can we send a text message?	Yes ☐	No ☐

I acknowledge and agree to these policies. _____

Your Initials

Patient Privacy Policies

We strive to comply with all federal and state medical privacy laws, which require us to protect the confidentiality and privacy of your records and personal information. We have implemented privacy policies and procedures to ensure compliance with these requirements, which are summarized in our Notice of Privacy Practices. We will only disclose confidential information consistent with state and federal law. We have offered you a copy of this Notice, and it is available on our website and upon request.

Child Abuse Mandated Reporting. Illinois law requires us to report all child abuse to the law enforcement. We must contact law enforcement if we have reasonable cause to believe that a child who is known to us in our professional capacity may be abused or neglected. It is our policy to first notify you.

● Please select one of the options below.

○ I <u>accept</u> a copy of the Notice.	○ I <u>decline</u> to receive a copy of the Notice but understand I may request it at any time.

I acknowledge and agree to these policies. _____

Your Initials

Medical Records Request Policy

We maintain records about your treatment. If you want a copy of your records, please ask us for a medical records request form. In some cases, we may charge reasonable and cost-based copying, postage, shipping, scanning, or digital storage device fees.

I acknowledge and agree to these policies. _____

Your Initials

Billing Policies

We are not contracted with any insurance company. This means that we do not accept or bill insurance on your behalf for our services or directly submit claims or communicate with insurers on your behalf. At the time of your appointment, you agree to pay us the full amount due for the services that we have provided to you. We will provide you with a "superbill," or an itemized bill that you can use when filing a claim with your insurance company for reimbursement. If you decide to file your own claims for out-of-network reimbursement, your insurance may not cover our services. If it does cover our services, it may do so at a lower out-of-network rate.

Please note that insurance companies do not reimburse for fees like late cancellation or returned check fees.

If you pay by check and that check is returned to us for any reason, you agree to pay: (i) your entire balance due, (ii) any returned check fees charged to us, and (ii) a $50 fee to cover Fast Track's billing services management of the situation. These three payments will be billed to the credit card you have provided below. In some circumstances, you may be responsible for supplies or equipment used through the course of your treatment. We will notify you and obtain your consent before you incur any such charges.

I acknowledge and agree to these policies. _____

Your Initials

Cancellation

If you need to cancel or reschedule your appointment, please contact us at least 24 hours before your scheduled appointment to avoid a late cancellation fee. If you cancel after that time, your credit card on file will be charged a $50 cancellation fee. Your insurance will not reimburse you for this fee.

I acknowledge and agree to these policies. _____

Your Initials

Your Credit Card

Credit Card Policy: We ask all patients to keep a credit card on file with Fast Track. You authorize charges for unpaid balances and fees of any kind to the credit card provided below. We will save this credit card information in your file for future charges.

Name on card: _____

Billing phone #: _____ *or same as* ○ cell # or ○ home # above.

Billing email: _____ *or same as* ○ email above.

Type of Card: ○ Visa ○ Mastercard ○ AMEX ○ Discover ○ Other: _____

Card number: _____ Exp. date: _____/_____ CVC: _____

Card billing address: _____

Address, cont. __ _____ *or same* as ○ address above

The cardholder hereby authorizes the above credit card to be charged for agreed purchases or services, including cancellation or returned check charges, and to be saved to our file pursuant to this Credit Card Policy.

Signature: _____ Date: _____

Acknowledgement and Agreement

My signature below demonstrates that I acknowledge, agree to, and authorize the following:

> *Agreement to this Document*: I have read and understand this entire document and agree to be bound by each and every part. I have truthfully and to the best of my knowledge provided the information requested. I agree to update Fast Track of any changes to my health. I have accepted or declined (as noted above) the Fast Track's Notice of Privacy Practices.

> *Coordination of Care Authorization*: I authorize the disclosure and use of my health information to the extent necessary to coordinate care with my primary care physician or other treating provider. I understand that I may revoke this authorization at any time by providing written notice to Fast Track's, except to the extent that we have has already relied upon it.

This document may be electronically signed. Electronic signatures on this agreement are the same as handwritten signatures for validity, enforceability, and admissibility purposes.

Signature: _____ Date: _____

For Minor Patients Only

If you are under the age of 18, please ask your parent or guardian to review your completed registration packet and sign below to indicate their consent to your treatment at Fast Track.

I, the undersigned, am the parent or guardian of this patient. I have reviewed this document and agree to be bound by it on my behalf and on behalf of the patient.

Printed Name: _____

Signature: _____ Date: _____

Informed Consent for Physical Therapy

This form will be completed together at your first visit.

Before we can provide services to you, Illinois law requires that we obtain your informed consent. You can provide us with your informed consent only after we have discussed the physical therapy services we will provide, the potential risks of the services, the potential benefits of the services, and any potential alternative services. Therefore, you acknowledge and agree that we will render the physical therapy services that we have discussed. These physical therapy services are documented in your medical records, and here, and you hereby consent to receive these services.

We have discussed the following information in terms that I understand. I have been informed of the risks, benefits, and alternatives of my treatment plan.

> The nature of my medical condition.

> Potential alternative treatments and their benefits and disadvantages.

> Any medications that I have been prescribed, and their dose, frequency, route of administration, and anticipated length of treatment.

> My provider at Fast Track has answered all of my questions about the recommended treatment. I understand how to contact my provider should additional questions arise.

We will provide a summary if necessary or applicable below.

1) Summary of the physical therapy services that we will provide (if necessary or applicable)

_____

_____

_____

_____

2) Summary of the potential material risks, benefits, and alternatives (if necessary or applicable):

_____

_____

_____

_____

As provided above, my provider has explained the services that I will receive, as well as the material risks, benefits, and alternatives. I agree and acknowledge that (i) the services may not have the results that I expect or desire; (ii) I have not been given any guarantees about the outcome of these services; and (iii) I have been offered ample time and opportunity to discuss my concerns, and all my questions have been answered to my satisfaction.

Please tell us immediately if you are pregnant or plan to become pregnant.

Signature: _____ Date: _____

For Minor Patients Only

If you are under the age of 18, please ask your parent or guardian to review this document and sign below. I, the undersigned, am the parent or guardian of the above referenced patient. I have reviewed this document and provide my informed consent on my behalf and on behalf of the patient

Printed Name: _____

Signature: _____ Date: _____