THERAPY HOUSE CALLS
IN-HOME THERAPY & REHABILITATION SERVICES

Phone: 631-645-1593
Fax: 631-448-4060
www.therapyhousecalls.com
Email: info@therapyhousecalls.com

PATIENT RESPONSIBILITIES, CONDITIONS & CONSENT FOR IN-HOME PHYSICAL THERAPY

Welcome to **Therapy House Calls, PT, P.C.** ("Therapy House Calls", "We", "Us", "Our", "Clinic"). By signing this document, you, the patient and responsible party (if applicable), agree to the following terms and conditions that will serve as our agreement upon which **in-home physical therapy services** will be provided to you.

1. Health Information. You are responsible for providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to your health. We may ask you to obtain a written medical clearance from your physician prior to commencing and/or resuming services with us.

2. Referrals. We may ask that you identify a physician and obtain a written referral for our services. If you do not have a physician and you wish to continue receiving physical therapy, we may ask you to consult with a physician to obtain a written referral prior to continuing treatment with us. If you have Medicare Part B, a physician or non physician provider (not necessarily your primary care physician) will need to sign your Plan of Care **within 30 days**. All other insurances may or may not require a referral for reimbursement.

3. Treatment Plan. You agree to remain active in your health, vocalize any pain/discomfort or other problems/concerns that you have with the recommended course of therapy and to accordingly follow the treatment plan recommended by those responsible for your care. As a patient, you have a right to give informed consent. You are an intricate part of your care. Your full participation is required to achieve the required treatment benchmarks. Physical therapy services are strictly confined to the allotted acts that we are licensed to perform as outlined in the **Article 136 of Title 8 of NYSED**, and as further restricted at our sole discretion.

4. Scheduling/Arrival. It is your responsibility to schedule appointments and follow through with your treatment plan. Please schedule your next appointment at the end of each physical therapy session. You are expected to be dressed in appropriate clothing to allow access to your involved area and ready for your appointment fifteen(15) minutes prior to your scheduled appointment time. Your therapist will make every effort to notify you and involve you in any alterations to your schedule. We appreciate any flexibility that you are able to provide with regards to rescheduling. Appointments will start promptly upon the therapist's arrival.

5. Missed/Late Appointments/Cancellations. Your failure to be prepared for your appointment on time will cause the following to occur: 1) your appointment time will not be extended; and 2) you will be billed for a full appointment irrespective of the actual start time. **"No-Shows"** will be noted if the therapist arrives to your location and you are not present and ready within fifteen (15) minutes. **No-Shows will be billed a $25 fee.** You may cancel, without penalty, with **24 hours advance notice** either by telephone or by email. We reserve the right to discontinue your treatment if you have **two (2) no-shows (or) three (3) cancellations in two (2) weeks.** Due to the nature of mobile services, there may be times where your therapist is late. Please ensure that when scheduling an appointment, you leave up to thirty (30) minutes of available time in the event that your appointment needs to be shifted. In the event that therapist is running late, therapist will call you as soon as he/she is made aware of the

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expected tardiness and either coordinate a later start time or otherwise reschedule for another date. In the event of inclement weather, we may cancel or reschedule your appointment out of safety concerns for our therapist(s).

6. Rates. Rates are subject to change. Please see the "Fee Schedule" for an updated schedule.

7. Payment.
7a. All patients: **You are responsible to call the insurance company ahead of time to obtain any pre-authorization (or) referrals necessary, and obtain verification of your out-patient physical therapy benefits. As a courtesy, Therapy House Calls, PT, P.C. will call your insurance carrier prior to initial evaluation, but ultimately it is your responsibility to confirm that the information Therapy House Calls, PT, P.C. received from insurance carrier is accurate.** Payment is due at the time of your appointment, or at our sole discretion, at the last scheduled visit of the calendar week. No "rain checks" will be accepted. At the time of this agreement, services will only be billed through Medicare for Medicare beneficiaries. No other third-party payor (Medicaid, Workers' Compensation, other health insurance or payors) will be billed. You will be solely and fully responsible for the charges incurred. We have a strict "no refund" policy. Payment must be received in order to schedule your next appointment. There is a **$35 bounced check fee** for payments that cannot be processed which will be assessed to you and due immediately. Failure to make full payment of your outstanding balance within **thirty (30) days or more** may result in suspension of future services and will accrue the following additional charges: **Interest Charge - 1.5% per month, 18% annual percentage rate and a collection fee of up to 4% of the full balance and/or legal charges if the account goes to collection**. We reserve the right to report non-payment to any credit reporting agency. We reserve the right to seek costs of enforcement and collections, including attorneys' fees, from you in the event that your non-payment incurs us such costs. Such fees will be subject to the aforementioned interest if paid later than thirty (30) days from date of demand. Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. While we may accept cases arising from automobile accident injury, you must pay your balance in full and negotiate repayment with any third party outside of our office.

7b. Medicare Part-B: We are a participating provider with Medicare, which means that all services provided to Medicare beneficiaries will be billed to Medicare. If you have a secondary/supplemental insurance, they will be billed for the remaining percentage. You are responsible for any copay, deductible, or allowable fees which are not paid by your insurance **at the time of service.** Medicare **will not** pay for any late/no-show fees and you will be responsible for their payment in full at the time of your next appointment. You are also individually responsible for all collections and other fees associated with paragraph 7a. You request that payment of Medicare benefits be payable to **Therapy House Calls, PT, P.C. (FEIN: 92-1242322)** on your behalf for services furnished to you. You authorize and direct that payment from any insurance or health care benefits otherwise payable to you for health care services or goods be made directly to **Therapy House Calls, PT, P.C. (FEIN: 92-1242322).** You certify that the information given in applying for payment under the Medicare program is correct. You request that payment of authorized benefits be made to **Therapy House Calls, PT, P.C. (FEIN: 92-1242322)** on your behalf for the clinic and therapist's charges for which the clinic is authorized to bill in connection with these health care services.

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8. Limitation of Liability. We are dedicated to preventing further injury and promoting your healing process but this can only be done with your full disclosure and cooperation. You understand and agree that you are engaging our services for a bona fide medical purpose and have been expressly cleared by a licensed medical doctor to seek out physical therapy services. As such, you are not seeking our services outside of the recommendation of a licensed medical doctor. You have fully disclosed to us all health-related information that is pertinent and necessary for proper treatment. In the event that you have a specific health condition, you have also disclosed the possible ramifications of such condition as it pertains to the structure and integrity of your skeletal, muscular and nervous systems. You have provided us with your full medical records including x-rays and MRIs along with the appropriate physician notations to properly explain observations about your specific case. It is your obligation to immediately stop any proposed course of therapy that causes you discomfort or pain and to immediately notify your therapist of such. It is your obligation to immediately stop therapy in the event that you experience an injury—whether in the course of receiving treatment or outside of treatment. You also understand that we have no control over the location where services will be rendered. As a result, you agree that you are fully assuming any/all risks associated with the location of your choice. **Failure to abide by these terms will result in forfeiture of any action or claims that you may seek against us as it relates to services provided to you and shall serve to hold us harmless from any and all such claims.**

9. Practice Guidelines. Our goal is to further your health goals. In some cases, therapy may be challenging. We strive to work with you to overcome physical hurdles and frustrations. As such, we expect that our therapists and staff will be treated respectfully at all times. This means that you will be open to your therapist's treatment recommendations and be fully present, without interruption, during your scheduled appointment time. As a condition of providing in-home services, we ask that you please secure pets from the treatment location; de-clutter the treatment area to accommodate for equipment and 360 degree movement; keep children and others who are not necessary to your treatment away from the area; and make necessary accommodations to allow your therapist comfortable ingress/egress with equipment especially in situations of inclement weather. This also means that you agree to make other reasonable accommodations if requested to do so. In the event that you are requesting services at a location other than your home, you understand that you will be fully responsible for obtaining any prerequisite approvals from the owner/manager of the premises and adhering to the above conditions. We reserve the right to refuse to provide services to you at the location of your choosing for any reason and may propose an alternate location. We further reserve the right to withdraw from providing your physical therapy services at our sole discretion.

10. Consent for Healthcare Services: You, the undersigned, voluntarily consent to and authorize the rendering of health care services, including routine clinical services, diagnostic procedures, and other services or procedures which your therapist or others holding clinical privileges consider necessary. You are aware that Physical Therapy treatment utilizes hands-on techniques which require the therapist to touch your body as part of the therapeutic process. You further understand that the practice of medicine is not an exact science and acknowledge that no promises or guarantees have been made to you regarding treatment or services rendered by the clinic.

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By signing below, you agree to all of the terms outlined above as a strict condition to obtaining physical therapy services, and further accept full financial responsibility as a patient or as the Responsible Party (guarantor) for such patient.

_____ _____

Patient Signature **Date**

_____

Patient Full Name (Printed)

_____ _____

Responsible Party Signature (if applicable) **Date**

_____

Responsible Party Full Name (Printed)

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I hereby acknowledge that I have received a copy of **The Notice of Privacy Practices**.

I hereby authorize use of disclosure of **Protected Health Information** about me as described below:

1. The following specific person or class of persons or facility is authorized to make the request to use or disclosure of Protected Health Information about me; any and all physicians, hospitals, clinics, medical care providers, insurance entities and government entities.

2. The following person or class of persons may receive disclosure of Protected Health Information about me: any representative of **Therapy House Calls, PT, P.C. (FEIN: 92-1242322).**

3. The specific information that should be disclosed is: any and all medical records, medical history forms, pain diagrams, narrative reports, treatment notes, transcript of radiology reports, psychiatric or psychological records, or other documentation including medical bills, statements for medical services rendered, pertaining to the person who has signed this authorization.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying all health care providers in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition treatment of me whether or not I sign the authorization.

6. This authorization expires in **two (2) years**, (or) upon occurrence of the following event that relates to me or to the purpose of the intended use of disclosure of information about me: _____

7. A copy or a fax of this authorization will be valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for copies of my medical records.

_____ _____

Signature of Patient (or) Responsible Party **Date**