CONSENT FOR MEDICAL TREATMENT

On behalf of myself, or as the patient's representative, I agree, acknowledge, and consent to the statements below related to my care at Acker Physical Therapy ("Acker PT"). This consent is valid for one year from the date of signature.

1. TREATMENT

I agree to be examined and/or treated in-person by Acker PT or its contracted providers. I acknowledge that the nature of the treatment, including its risks, benefits, and alternatives, has been explained to me, and I have had the opportunity to ask questions.

I agree to provide complete, accurate, and timely demographic information to Acker PT, including the correct patient and guarantor information, such as name, mailing address, phone number, and email address. I will also provide an emergency contact name and phone number.

2. PAYMENT

I am responsible for providing complete, accurate, and timely insurance information to Acker PT. I accept full financial responsibility for balances due to my failure to provide accurate information. I agree to provide current and accurate billing information, such as a credit card number. I allow Acker PT to store my credit card information in their records.

I authorize Acker PT to bill my insurance and other third-party payers directly for health care charges and fees. I am responsible for payment of balances not covered by my insurance or benefit plan, including any out-of-pocket expenses or fees processed by my insurance company. I understand that it is my responsibility to know and understand my insurance benefits. I authorize Acker PT to submit a HCFA 1500 claim, or any other necessary claims, for each visit.

I agree that Acker PT may contact me at any phone number associated with my account to collect any amounts I owe. Methods of contact may include prerecorded messages or an automatic dialing service, including text and iMessages.

3. RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND OPERATIONS

I understand that my records may be used or disclosed for purposes of treatment, payment, and operations. I acknowledge receipt of Acker PT's Notice of Privacy Practices, which fully describes how Acker PT will use and disclose my health information.

I authorize my protected health information to be used and disclosed by Acker PT to assist in the collection and payment of charges not covered by my insurance.

I authorize Acker PT to release my records to show evidence of care provided when requested by any third parties who will make or have made payments related to my care.

4. PHOTOGRAPHS

I understand photographs and recordings may be taken of me during my care for purposes of identification, diagnosis, treatment, safety, security, quality assurance, and education. Unless required by law, the disclosure of these photographs and recordings for any other purpose requires my separate, express written consent.

5. PERSONAL PROPERTY/LIMITATIONS OF LIABILITY

I understand that Acker PT is not responsible for the loss of or damage to my personal property. If I have valuables at Acker PT I will arrange to have them sent home or accept all risk for loss or damage. I leave my personal property at Acker PT at my own risk.

6. COMMUNICATIONS

I agree for Acker PT to contact me or my authorized representative regarding my health care, appointment reminders, or alerts through any means deemed appropriate, including but not limited to telephone, email, and unsecure text and iMessages. If I receive a text or iMessage and do not want to receive further messages, I can respond by texting the word “STOP” to opt-out. Message and data rates may apply.

Printed Name of Patient: _____

Signature of Patient or Legal Representative: _____

Date: _____

Authority of Legal Representative, if applicable: _____