SPECIALIZED PHYSICAL THERAPY

"Restoring Quality of Life"

Consent and Conditions for Physical Therapy

CONSENT TO TREAT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Specialized Physical Therapy (SPT). At SPT, we use a variety of treatment procedures to help us try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain treatment procedure. We are not able to guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. You have the right to ask your physical therapist what the potential risks and benefits of a specific treatment procedure might be. You have the right to decline any portion of your treatment at any time before or during the treatment session.

RELEASE OF INFORMATION

I have received a copy of the privacy notice. I hereby authorize the release of any information by telephone, fax, secured email, or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Specialized Physical Therapy, LLC (SPT) to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of any information by telephone, fax, secured email, or in writing for utilization and quality review purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to SPT for any services that are reimbursable by Medicare and any third party sources.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by SPT, I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible, which I am fully responsible for paying. Payments may be made in cash, check, or credit card (Mastercard/Visa/Discover). Although SPT will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify SPT of any changes in my insurance coverage while receiving physical therapy. I agree to abide by the Patient Missed Appointment Policy (you will be given a copy of the policy).

I, _____, by signing this document, acknowledge my consent to the above:
(Print Name)

Signature: _____ Date: _____