Specialized Physical Therapy

IPTA Consent and HIPAA Form

Please fill out the details.

AGREEMENT TO PAY FOR SERVICES RENDERED

It is understood and agreed that you are ultimately responsible for the balance of your account for any professional services rendered. It is also agreed that if insurance denies for any reason all charges will be your responsibility. It is also understood that if for any reason (NSF check, etc), costs (collection, attorney fees, court costs, etc.) IPTA Clinical ("us"), to collect outstanding balance, these will be your responsibility and will be added to your account balance for collection. IF A REFERRAL OR PRESCRIPTION IS REQUIRED BY YOUR INSURANCE, IT IS YOUR RESPONSIBILITY TO OBTAIN ONE AND BRING IT WITH YOU ON YOUR 1ST VISIT. IF YOU DO NOT, ALL CHARGES INCURRED DUE TO INSURANCE DENIAL WILL BE YOUR RESPONSIBILITY.

CANCELLATION/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for family or work. We pride ourselves on the personal care that you receive here and expect from us and only schedule patients every ½ hour. We ask that you please give us a 24hr notice of cancellation so that we may accommodate other patients that we were not able to schedule in that time slot. Failure to provide 24 hour notice of canceling may result in a fee of $50.00.

CONSENT TO TREATMENT

I acknowledge that I am voluntarily seeking care from IPTA Clinical. I authorize a licensed Physical Therapist to conduct an evaluation to determine a plan of care. I further authorize a licensed Physical Therapist to provide treatment based on an agreed upon plan of care. I acknowledge that there are some risks inherent with Physical Therapy. I understand that I have the right to question any care being provided and refuse recommended treatments. I acknowledge that the Physical Therapist is acting in my best interest, and cannot guarantee that desired results will be obtained.

CONSENT TO MEDICAL INFORMATION

When appropriate for my care, I authorize IPTA Clinical, access to medical information from other providers, which includes, but is not limited to, imaging reports, operative reports, and physician notes.

Acknowledgement of HIPAA

I acknowledge that at my request I will be offered and receive information on the HIPAA policy.

I authorize IPTA Clinical, to discuss my Physical Therapy care with the following individuals:

1._____

2._____

3._____

Print Patient's Name:_____

Patient/Guardian Signature:_____ Date:_____