WoMen's Physical Therapy
INSTITUTE

PATIENT CONSENT FORM Account # _____

Please read and sign below - All information provided herein is true and correct:

Consent to Treatment: I consent to physical therapy treatment at *WoMen's Physical Therapy Institute (WPTI)* under the prescription of my referring practitioner.

Information Release: I give permission to WPTI to release information, verbal and written, contained in my medical record, and other related information, to my physician, insurance company, rehabilitation nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons.

Privacy of Information: I acknowledge that WPTI has made available a copy of their HIPAA Privacy Policy, located in the waiting area of the clinic. A copy may be obtained for my records by request. Information without patient identifiers may only be used for quality assurance and/or outcomes purposes (i.e.-research).

Payment Responsibility: I expressly guarantee full payment of this account for all services rendered by WPTI. Regardless of my quoted insurance benefits, *I understand that I am fully responsible for all charges incurred*. WPTI will file all claims to my insurance carrier and my insurance carrier will either: 1) reimburse WPTI directly if they are in-network with my insurance plan, or 2) reimburse me for these services and I am then responsible to remit payment in full to WPTI. If I have insurance benefits for physical therapy, *I am expected to remit payment at each visit for my quoted deductible balance, coinsurance or copayment*.

Cash Payment – No Insurance: If I have no insurance coverage to be billed by WPTI, I understand that payment is due in full to WPTI at the time of service. WPTI's cash patient option provides a 15% discount off of total treatment charges (does not apply to durable goods purchased).

Medicare Patients: I have been informed that Medicare applies a combined 2017 annual limitation for physical therapy and speech language pathology services of $1,980.00. I understand that I am responsible for my 2017 annual deductible of $183.00, any remaining balance after Medicare and my supplement have paid, and 100% of the charges if I exceed the $1,980.00 annual limitation. I have also been informed that Medicare does not allow for any overlap of outpatient physical therapy services with home health care and/or services provided at a skilled nursing facility. It is my responsibility to confirm my home health discharge date. I am responsible for all charges denied by Medicare that overlap with home health care.

Durable Goods Payment: I have been informed that my insurance may not cover charges incurred for any durable goods purchased, including sales tax. *I am responsible to pay all durable goods in full at the time of service*. WPTI can provide me a receipt for such purchases that I can submit to my insurance for possible reimbursement. I understand that I am fully responsible for all charges incurred.

Auto Insurance Patients: I have been informed that WPTI will not bill third-party auto insurance carriers, as they will not pay my medical bills until the claim is settled. WPTI will bill all claims to either my confirmed auto carrier and/or my health insurance for charges related to an auto accident. It is my responsibility to inform WPTI if my auto insurance medical benefits have been exhausted at any time during my course of treatment with WPTI. My auto insurance carrier will not inform WPTI when I reach or exceed the medical benefit. I am fully responsible for all unpaid balances, including all deductible, coinsurance or copayments at the time of service.

X_____

Patient Signature (or Guardian if a minor) Date