PhysiYo

_____

Patient Name (Please Print)

2023 Patient Information Consent Form

Please read and INITIAL each section and SIGN the last page

Consent to Physical Therapy Evaluation and Treatment

_____I hereby consent to the evaluation and treatment of my condition by a licensed Physical Therapist/Physical Therapy Assistant employed by PhysiYo. The Physical Therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The Physical Therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment. I understand that an Initial Evaluation is required at my first visit and with any new or additional injuries/episodes.

Health Insurance Portability and Accountability Act (HIPAA)

_____I have read and fully understand PhysiYo's Notice of Information Practices. I understand that PhysiYo may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I hereby consent to the use and disclosure of my personal health information for purposes as noted in PhysiYo's Notice of Information Practices.

CHOOSE ONE FORM OF PAYMENT (A or B):

A. Insurance

_____ I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original. I authorize payment of medical benefits to PhysiYo for services rendered. (PhysiYo will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.)

Name of Policyholder_____ Policyholder DOB_____

Relationship to Patient_____ Policyholder SSN _____
(required for auto claims)

B. Self Pay

_____I elect and agree to the self pay amount of $100.00/Physical Therapy session (3-4 units). I understand additional therapies may add to this amount if I request them. If I so choose, it is my responsibility to submit for any insurance reimbursements on my own. I understand that my first visit will require an Initial Evaluation with a PT. I understand cash, credit card, or check is accepted at the time of treatment.

Continued on next page

Late Cancel/No Show Policy

_____I understand I may be charged a cancellation fee if I no-show or break an appointment with less than 24 hours notice. Though PhysiYo provides courtesy reminders, I acknowledge it is my responsibility to remember my appointment. *Please call our office ASAP if you cannot come to an appointment already scheduled.

Text/Email communications (OPTIONAL)

_____I understand that text messaging/email may not be secure, however, I authorize PhysiYo to communicate with me (including reminders for my appointments) through text and/or email. I understand that my Protected Health Information should be kept to a minimum.

Permission to Share Information (OPTIONAL)

_____I give permission for PhysiYo to VERBALLY share information with family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. This could include: Medical information, including my symptoms, diagnosis, medications and treatment plan, Scheduling/Appointment information, and/or Billing and Payment information.

Name:_____ Phone:_____
(First) (Middle) (Last)

Name:_____ Phone:_____
(First) (Middle) (Last)

I have read and understand the above consents, assignment of benefits, release of information, and payment authorization above. This "Signature on File" will be valid from this date and shall expire with my written request. A photocopy of this document may act as original.

_____
Patient/Guardian Signature

_____
Date

How did you hear about us?_____