Phoenix
Physical Therapy

CONSENT FOR TREATMENT AND FINANCIAL POLICY

Patient Name: _____ DOB: _____

We would like to **THANK YOU** for choosing Phoenix Physical Therapy (PHX PT). PHX PT accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurance companies pay a predetermined amount of our treatment charges; however, it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however, we do not take responsibility for any misinformation that we are given during this process. It is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm with our office prior to initiating treatment.

CONSENT FOR CARE AND TREATMENT

I hereby consent to the provision of treatment by PHX PT. I authorize PHX PT to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition. It is possible that my participation in the visit could result in injury to me. I also acknowledge and fully understand that I am engaging in activities that may involve the risk of economic or other damages which might result from my own actions or omissions, from the actions or omissions of other parties, or from any of the activities I am asked to complete during this visit. I further agree that there may be other risks not known to me or not reasonably foreseeable at this time. Nonetheless, it is my desire to participate in this visit. Accordingly, I release, waive, discharge and covenant not to sue PHX PT, any of its employees, representatives, officers, directors, shareholders, affiliates, administrators, agents, owners, or lessors of all equipment, all of whom are hereafter referred to as "Releasees", from demands, losses, or damages on account of injuries, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the Releasees or otherwise.

I hereby authorize and designate the following individual to act in all matters in connection with my treatment by PHX PT, including, without limitation, discuss my therapy plan of care, and schedule and cancel my appointments:

_____

First and Last Name Phone Number Relationship to Patient

FINANCIAL RESPONSIBILITY

I understand that in some instances my health insurance may not cover all treatment charges incurred. I agree to be financially responsible to PHX PT for any medically necessary therapeutic services that are not covered by my health insurance carrier. In addition, I authorize PHX PT to release (a) any medical or other information about PHX PT services, or services provided by third parties, if required to obtain payment from my insurer or other payer and their agents to process payments; (b) any medical or other information required by my insurer, other payers and their agents; and (c) medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to PHX PT any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by PHX PT for treatment. By way of my signature below, I provide PHX PT with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES

I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit, according to my insurance benefits and the following PHX PT policy to reduce the balance billed to me at the end of care: Copays are collected in full at the time of service. Balances towards deductible and coinsurance will be collected as insurance(s) processes claims throughout the course of treatment. Any outstanding balances due at the end of each month will be billed to the patient.

Patient Name: _____ DOB: _____

LITIGATION ACCOUNTS

With respect to litigation against another party, I understand that PHX PT will directly bill my appropriate insurance; however, I am responsible for the payment of my treatment, not the entity being sued. Liability action against another party will not enable me to refuse payment to PHX PT. I fully understand that I am directly and fully responsible to PHX PT for all medical bills submitted by PHX PT for services rendered to me regardless of whether my claims are settled or result from a court judgement.

PATIENT VALUABLES

I relieve PHX PT of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that PHX PT will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS, FINANCIAL RESPONSIBILIBITIES AND OTHER HEALTHCARE COMMUNICATIONS

I consent to receive calls/texts/emails from PHX Physical Therapy regarding my patient health information, statements, and other services at the phone number(s) or email addresses listed, including my provided wireless number. These calls/texts/ emails may include information such as appointment dates and times as well as other financial responsibilities due and other pertinent information. I understand I may be charged for such calls/texts by my wireless carrier. I understand that I can revoke consent to receive such calls/texts/emails at any time by opting out.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)_____ I am entitled under State Law to consent to medical or other health services for myself, and if applicable, for my minor children without the consent of any other person: _____ Patient Initials (required if completing this section)

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

FOR PHOENIX PHYSICAL THERAPY OFFICE USE ONLY

Verification of the identity of the above-named party was made by:

☐ Current Driver's License or other Photo ID

☐ Current Health Insurance Card

☐ Other:

I have read this Consent for Treatment and Financial policy form or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all PHX PT facilities.

_____ _____

Signature of Patient or Guardian (if patient is a minor) **Date**

_____ _____

Signature of Phoenix Physical Therapy Representative **Date**