LOGO of PRACTICE

AUTHORIZATION TO TREAT: I voluntarily consent to therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize FACILITY to provide such treatment. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION. I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES RENDERED.** Initials _____

PAYMENT AUTHORIZATION: I understand that all balances designated as 'the patient's responsibility' such as co-insurances, co-payments and deductibles are due and payable to FACILITY. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. As part of working with my insurance carrier, I recognize that FACILITY may be provided with information about my insurance coverage, and that on occasion FACILITY may share some of this information with me. However, I understand FACILITY is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. This is not a guarantee of benefits. Initials _____

We have contacted your insurance company and they reported the following information. Deductible $_____. Co-insurance amount _____%. Co-pay amount $_____. Visit Limit_____. If your deductible has not been met or you have a balance, we would be happy to receive payment for your therapy services at each visit.

INSURANCE BENEFITS ASSIGNMENT: I authorize that the payment of my insurance benefits be made directly to FACILITY for all services delivered; if I am paid directly I will promptly pay FACILITY all monies paid to me.
Initials _____

HIPAA PRIVACY POLICY: My signature below indicates that I have been given the Notice of Privacy Practices for FACILITY. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to FACILITY to release any of my protected healthcare information. Initials _____

CANCEL/NO SHOW POLICY: You may be charged $30 if you cancel less than 24 hours prior to your scheduled appointment or do not show up for an appointment. You may request a copy of our Cancelation Policy.
Initials _____

RECORD RELEASE: I am aware that FACILITY may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care.
Initials _____

I would like FACILITY to disclose my Protected Health Information to individuals other than those listed above.
YES NO **(If YES, you must complete an Authorization to Release PHI form)**

REMINDER CALLS: As a service to patients, we provide appointment reminder call and other calls (ie. Weather closure) that maybe placed using prerecorded message. By providing your number, you consent to receive such calls.
Phone Number: _____ Phone Carrier: _____Email: _____
Initials _____

Date: _____ Patient's Printed Name: _____

Signature of Patient or Patient Representative: _____
Patient Representatives Printed Name and Relationship if applicable: _____

REVIEW AND INITIAL BELOW ONLY IF APPROPRIATE

MEDICARE PATIENTS ONLY: Are you currently, or in the last 30 days have you received any type of Home Health Services, therapy from a home health care agency, transitional care facility, or nursing home?: YES NO If YES, we cannot treat you until you have been discharged. Medicare will not pay our services. You may request Medicare Cap information. Initials_____

SELF REFERRAL OR OUT OF STATE REFERRAL: I understand that if I have been referred by a physician who is not licensed in the state of MN and I am being treated at a clinic in MN, I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a physician who is licensed in the state of MN. The same 90 day rule pertains if I have not been referred by a physician and I am self-referring. Initials _____

PAYMENT AUTHORIZATION – PROMPT PAY: Your services will not be billed to your insurance company or do not qualify for coverage. Charges must be paid in full at the time of service in order to receive the prompt pay discount. The amount charged is determined by the case's complexity. Cost of the evaluation is $_____and follow up is $_____. If a supply or orthotic is issued, there will be an additional charge. I do not want my services billed to an insurance company, and will not do so myself.

Initials _____

TELEHEALTH/E-VISIT APPROVAL: I approve the possibility of being seen by a clinician via telehealth for some portion of my care. Initials _____