Asheville Physical Therapy
Orthopedics • Sports Medicine • Sports Performance ™
76 Peachtree Rd, Suite 204 · Asheville, NC 28803 Phone 828·277·7547 · Fax 828·277·7540

2021
CONSENT TO TREATMENT

Please initial and sign consent form for treatment.

_____I understand that Asheville Physical Therapy (A.P.T.), may use or disclose my personal health information for the sole purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to the treatment and payment.

_____I have read and understand the patient bill of rights (Notebook in front waiting area). I understand that it may be necessary for me to be treated and / or perform exercise in an open gym area where there may be other patients present. I also understand that if I am not comfortable with this arrangement, I may notify my therapist.

____I understand that any deductible, co-pay, and co-insurance or percentage of payment that I am responsible for, is due at time of service, and may not become fully clear, until claims have processed, and an Explanation of Benefits (EOB) has been generated by my insurance carrier(s). **A.P.T. staff will otherwise need to reschedule my appointment if I am not prepared to pay for my part. (Patient's/Guarantor's credit card number to be on file to process payments. If there are any concerns, please contact A.P.T. Co-Owner / Office Manager).**

Insurance Patient:

_____I understand that it is ultimately my responsibility to be familiar with my insurance policy benefits, including any OUT OF NETWORK BENEFITS, and that it is my responsibility to contact customer service with any inquiries or concerns, as needed.

_____I UNDERSTAND THAT A.P.T. WILL PROCESS OUT OF NETWORK CLAIMS, (if my insurance carrier is out of network with Asheville Physical Therapy),BUT HAS NO GUARANTEE OF THE AMOUNT OF PAYMENT BY MY CARRIER, AS BENEFITS VARY. FAIR AND STANDARD FEE FOR SERVICE WILL BE COLLECTED FROM THE PATIENT, UPFRONT PER A.P.T. POLICY, AT THE TIME SERVICE IS RENDERED. THE ACCOUNT MUST BE SETTLED, ONCE THE CLAIM AMOUNT IS FULLY KNOWN, (UPON A.P.T. RECEIVING THE E.O.B. FROM THE INSURANCE CARRIER). IF THERE IS PAYMENT OVERAGE BY PATIENT, THEN A.P.T. WILL ISSUE A REFUND. IF PATIENT OWES A.P.T.,THEN CREDIT CARD ON FILE WILL BE PROCESSED FOR AMOUNT DUE, AND RECEIPT TO BE MAILED TO PATIENT.

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_____I understand that is also my responsibility to render payment for services received if my insurance company fails to do so. I understand that A.P.T. attempts to obtain accurate information about my benefits from my insurance company prior to treatment, however, the insurance information provided is not always accurate, timely, or reliable.

_____I understand that it is my responsibility to provide accurate/ up to date insurance cards and general information, INCLUDING any address/ name change.

_____I understand that I, the patient/ patient's guarantor **must** notify APT **within 7 days** of any changes in the forementioned, for billing accuracy.

Medicare Patient:

____I understand that Medicare (MCR) will cover 80% of the allowed charges per calendar year for services that are medically necessary, and treatment is approved by the physician. (There will always be a Medicare Deductible at the beginning of each calendar year. The Deductible amount changes, per Federal Policy, annually. This must be met and paid to the provider, before Medicare will begin to cover payment for medical services AND will be collected at the time service is rendered. (Rarely, a secondary insurance carrier may cover this expense, and it is the patient's responsibility to call and learn about his/her secondary policy; If this information is unknown, then payment would be the responsibility of the patient, upfront for the Medicare Deductible.

____If an overage is paid by the patient, to A.P.T., it will be refunded to the patient, at the end of the patient's therapy.

____The patient or the patient's secondary insurance is responsible for the 20% coinsurance that Medicare does not pay, according to the patient's insurance carrier. If there are questions regarding secondary insurance coverage, the patient is to call his/ her insurance carrier.

____I understand Medicare's imposed financial limitations on therapy services and will comply with the financial guidelines. I will contact my insurance carrier(s) if I have specific questions about my policy.

Self-Pay Patient:

____I understand that APT **will not** bill my insurance company. I have chosen a self-pay rate and I am responsible for a flat fee, at the time services are rendered. Asheville Physical Therapy will NOT be held responsible to supply the patient with treatment fees or diagnosis codes. I can submit a flat fee to my insurance for reimbursement consideration. A receipt for payment will be offered by APT. (Any other attempt to collect by the patient, from major medical insurance, is considered insurance fraud).

Parent/Legal Guardian of Dependent patient:

_____I understand that if my dependent child brings him or herself to an appointment, any deductible, co-pay, co-insurance, or percentage of payment that I am responsible

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for, is due at time of service. The dependent child / patient must have a credit card on file or a valid form of payment at the time services are rendered. **If A.P.T is unable to collect payment at the time services are rendered, the staff must reschedule the appointment and a late cancellation fee of $35.00 will be charged to the card on file.**

Unpaid balances:

____ **I understand that unpaid balances greater than 30 days old will result in an 18 % interest penalty unless arrangements have otherwise been approved by management. (**I understand that liability action against someone is not a reason for delaying payment of my bill. Payment is my responsibility as an individual receiving treatment).

____**I UNDERSTAND THAT A.P.T. POLICY REQUIRES HAVING THE PATIENT'S / GUARANOR'S CREDIT CARD ON FILE, AND BY INITIALING, I AM AGREEING THAT A.P.T. MAY PROCESS PAYMENT USING MY / GUARANTOR'S CREDIT CARD TO SETTLE ANY UNPAID COPAYS, CO-INSURANCE, UNPAID BALANCES, INCLUDING LATE CANCELLATION/NO SHOW FEES. A RECEIPT SHOWING PAID IN FULL WILL BE MAILED TO THE PATIENT / GUARANTOR ONCE THE PAYMENT HAS BEEN PROCESSED.**

Late cancellations and No shows:

____I understand that if I am going to be late for an appointment, A.P.T. expects a courtesy call from patient / patient guarantor. My timeslot may likely be forfeited if I am more than 15 minutes late. (I will make every reasonable attempt to notify A.P.T. if I am running late for any reason).

_____ If I am unable to attend an appointment, I will notify A.P.T. at least 24 hours prior to my scheduled appointment. **A fee of $35.00 will be charged to my / the guarantor's credit card on file, if I fail to show for a scheduled appointment AND/OR if I have more than 1 late cancellation (which is considered less than 24-hour notice).**

____**I UNDERSTAND THAT A.P.T. POLICY REQUIRES HAVING THE PATIENT / GUARANTOR'S CREDIT CARD ON FILE. BY INITIALING, I AGREE THAT THE CREDIT CARD ON FILE MAY BE USED WHEN NECESSARY TO PROCESS PAYMENT FOR ANY LATE CANCELLATION AND / OR NO-SHOW FEES. IF MY CARD DECLINES FOR ANY REASON, I WILL PROVIDE AN UPDATED CARD.**

____ **I UNDERSTAND THAT THE TIMESLOTS FOR THERAPY ARE IN HIGH DEMAND, LIMITED, AND I WILL TRY TO ADHERE TO THE CANCELLATION**

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(CONTINUED) POLICY, UNDERSTANDING, THAT THERE IS WAIT LIST, AND IF I AM UNABLE TO GIVE AMPLE TIME, AS NOTED IN A.P.T.'S CONSENT TO TREAT, (AMPLE TIME IS >24 HRS), THEN I UNDERSTAND THAT I WILL BE CHARGED, $35, AS NOTED.

***A.P.T. OWNERS ALSO UNDERSTAND THAT THE UNFORSEEN OCCURS AND ALLOW "1 GRACE", TO ACCOUNT FOR "LIFE HAPPENINGS". WE AIM TO PROVIDE CONSISTENT, PUNCTUAL, HIGH QUALITY, INDIVIDUALIZED CARE. THIS SERVICE INDUSTRY/ HEALTH CARE BUSINESS RUNS ON A TIME SENSITIVE SCHEDULE. THANK YOU FOR YOUR UNDERSTANDING, AS THIS ALLOWS US TO SERVE AND PROVIDE YOU WITH THE BEST CARE.**

CONSENT TO TREATMENT:

_____ I understand that my participation in Physical Therapy is voluntary and by choosing to participate, I am consenting to all rendered services, as deemed medically necessary or appropriate by my therapist. I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from A.P.T.

_____(If non-applicable, please insert "N/A" on the blank line). I agree, with each visit, to accompany my underage dependent child/ patient, (under the age of 18). **IF OTHER ARRANGEMENTS NEED TO BE MADE BETWEEN A.P.T. AND THE PARENT / GUARDIAN, THEN A WAIVER WILL NEED TO BE SIGNED.**

PLEASE Print Name of Patient (18 yrs+) or Parent/Legal Guardian: _____

Signature of Patient (18 yrs+) or Parent/Legal Guardian: _____

Date: ____/____/_____

Reviewed By: _____

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Patient HIPPA Notification Policy and Consent

In order to ensure that patients receive time-sensitive information and other documentation all healthcare messages, we, as the provider of rehabilitation therapy ("Provider", "we," or "our") send notifications to patients that opt-in to receive such notifications. If you (patient is referred to herein as "you," "I," "me," "my," "yourself," and "your") choose to sign this consent and opt-in to receive such notifications from Provider, Provider will not impose a separate charge for these notifications; however, depending on the terms and conditions of your wireless carrier contract and/ or plan, fees and/or restrictions may be imposed upon you for receiving notifications from Provider. Please contact your wireless carrier about such fees and/or restrictions prior to providing your consent herein to such notifications from Provider.

It is important to note that certain communications, including, without limitation to email and text message, which may contain your protected health information ("PHI"), are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), we are required by law to maintain the privacy and security of your PHI. In addition, pursuant to the HIPAA Privacy Rule and Provider's Notice of Privacy Practices, we will not use and/or disclose your PHI without your explicit written authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, when we are authorized and/or permitted to use and/or disclose your PHI, we will limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose of the use and/or disclosure of your PHI. If you choose to have Provider disclose your PHI to an individual or entity other than yourself, you must properly complete Provider's HIPAA Authorization Form, which is available at the front desk upon request.

You have the right to revoke this consent by providing written notice of revocation to the Privacy Officer at Asheville Physical Therapy. The revocation will become effective on the day the Privacy Officer receives the revocation of the consent, and any prior notification from Provider will not be subject to such revocation of the consent.

I, the undersigned, hereby consent to receive notifications from Asheville Physical Therapy, which notifications may include my PHI, by the following methods of communication that I indicated below, with a full understanding of the risks involved with

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(CONTINUED) PATIENT HIPPA NOTIFICATION AND POLICY AND CONSENT

such notifications from Provider, and I agree to assume all responsibility for informing Provider in writing of any changes to any of the methods of communications that I indicated below and for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable, and I further agree that Provider shall not be held liable for any unauthorized disclosures of my PHI to a third party through any of the methods of communication.

Patient's Name: _____DOB: _____

1. RELEASE OF PRIVATE HEALTH INFORMATION:

I authorize the following to have access to my PHI information with what limitations that I may set forth:

Name: _____ Relation:_____

Medical Records: yes or no

Billing and Account: yes or no

Appointments: yes or no

2. APPOINTMENT REMINDERS:

I authorized Asheville Physical Therapy to remind me of my appointments at:

Phone: (_____) _____

Email _____

I have read and give the above permissions to Asheville Physical Therapy.

Patient/Legal Guardian Signature: _____Date: _____

Patient/Legal Guardian Name: (Print) _____

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