CARPENTER
Physical Therapy

Our Practice Policies

Please review and initial each of these policies. If you have questions, please ask!!

Examination of Health Records

To receive a copy of your health records, please ask your provider for a Records Release Authorization form. Please note that copying, postage, shipping, scanning, or digital storage device fees may apply.

I have read and understand this policy and agree to be bound by its terms. *Client initials:* _____

Appointment Cancellation & Rescheduling

We understand that you are busy and that your schedule may change. If you need to cancel or reschedule your appointment, please contact us at least 24 hours before your scheduled appointment to avoid a cancellation fee.

Because appointments are in high demand, you will be charged a $40.00 fee if you miss an appointment ("no show"), or if you cancel or reschedule your appointment within 24 hours of your scheduled appointment.

I have read and understand this policy and agree to be bound by its terms. *Client initials:* _____

Self-Payment for Services

If you do not have insurance or you do not want us to bill your insurance, you must pay your balance in full at the time of service. Regardless of whether we have collected or verified your insurance information, we do not guarantee that you will be reimbursed by any third party. You agree to pay any bank fees for returned checks. You further agree to endorse over to us any payment provided to you from your insurance company for which you have an outstanding balance with our practice.

If you later decide to request reimbursement from your insurance company, please ask us for the necessary documentation within 6 months of the date of your appointment to which it pertains. Your submission of a claim to your insurance company does not guarantee that you will be reimbursed.

I have read and understand this policy and agree to be bound by its terms. *Client initials:* _____

Privacy

You have been given or offered a copy of our Notice of Privacy Practices, which summarizes the detailed policies and procedures that we implement to protect your personal health information.

I have read and understand this policy and agree to be bound by its terms. *Client initials:* _____

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Indemnification & Assumption of Risk

As a condition of receiving our services, you agree to indemnify us against all claims, liabilities, losses, damages, suits, costs, and expenses, including reasonable attorney's fees, relating to our services to you, except to the extent that such a claim is caused by our gross negligence or willful misconduct. Furthermore, you agree to assume all risk of property damage, injury, and/or death associated with the services that we provide to you. The terms of indemnification and assumption of risk shall survive the expiration of your treatment and be as broad as permitted under law. If any portion of this provision is found to be unenforceable, a court shall have the power to modify the unenforceable provisions and enforce the remainder of these terms.

I have read and understand this policy and agree to be bound by its terms. *Client initials:* _____

Insurance

If you would like assistance with being reimbursed by your insurance company, please complete the following:

Insurance company name:_____ ID: _____

Group number: _____

Insured's name: _____Relationship to patient:_____

Insured's date of birth:_____ Insured's phone number: _____

Insured's address: ☐ Same as patient or ☐ other:

_____

No Guarantee of Benefits: ***We currently do not accept third party insurance.*** Verifying your insurance coverage, benefits and reimbursement eligibility is your responsibility. You are responsible for paying any amount that your insurance company does not pay, which may be 100% of our fees.

Upon your request, we will provide you with the documentation necessary to submit a claim to your insurer.

I have read and understand this policy and agree to be bound by its terms. *Client initials:* _____

Payment Guarantee - Credit Card

Some of our fees (e.g. cancellation fee and administration fees outlined below) will will be your sole responsibility. Accordingly, please compete the following credit card authorization, which we will use to satisfy the above-referenced fees.

Name on Card: _____ Phone: _____

Email: _____

_____ _____ _____ _____
Billing Address City State ZIP Code

Type of Card: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover Other: _____

_____--_____--_____--_____ _____/_____ _____
(Credit Card #) (Exp. Date) (CVV)

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ADDITIONAL CHARGES:

An addition charge of **$50.00** ***(administrative fee)*** **AND** **$100.00** ***(clinical documentation fee)*** will be applied should the patient intend to submit proof of payment for services rendered to their health insurance company for reimbursement. **It is the patient's responsibility to notify the office of their intent** ***prior to scheduling any appointment(s).***

Requesting assistance or for updated documentation for your insurance company after your session(s) has/have occurred will not be honored.

By signing and dating below, I am confirming I have been informed of the additional charges related to insurance reimbursement assistance. By checking one of the boxes below, I am informing **Carpenter Physical Therapy, PLLC.** of my intent regarding submitting proof of payment for services rendered to my insurance company and agree to the additional charges, should I elect to do so.

I intend to submit my proof of payment to my insurance company for reimbursement: ☐ **YES** ☐ **NO**

I agree to the additional charges: ☐ **YES** ☐ **NO** ☐ **I will not be submitting proof of payment to my insurance for reimbursement**

Name:_____ **Signature:**_____ **Date:**_____

Agreement & Acknowledgment

As provided in these policies, by signing below, I agree, acknowledge, and authorize that:

- ✓ I have completed this form truthfully and to the best of my knowledge.
- ✓ I am bound by Carpenter Physical Therapy's practice policies.
- ✓ I am bound to indemnify Carpenter Physical Therapy and voluntarily assume all risk.
- ✓ Carpenter Physical Therapy may charge my credit card as described above. I affirm that I am authorized to use this credit card, that I will not dispute any charge for services rendered, and that this authorization is valid until revoked in writing.

_____ _____

Signature Date

If you are under the age of 18, please have your parent/guardian review and sign.

_____ _____

Parent/guardian Signature Date

Thank you for reviewing our policies. We look forward to meeting you.

For the Practice's use:

☐ Patient offered opportunity to ask questions.
☐ Patient offered "Notice of Privacy Practices: ☐ Accepted ☐ Declined
☐ Minor Patient: Release was signed by parent/guardian

Initials of reviewing clinician: _____ Date: _____

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INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

You and your provider will complete this form together

I,_____ , acknowledge that Carpenter Physical Therapy, through its owners, agents, or employees, will provide the following physical therapy services ("PT Services").

For the Practice's use. *Describe: (1) PT services to be rendered, (2) material risks and benefits of these services, and (3) information about alternatives*.

I further acknowledge that:

- ✓ These PT Services and their material risks and benefits have been explained to me.
- ✓ These PT Services may not have the result that I expect. I have been informed as to other possible services that may provide me a benefit.
- ✓ PT Services are not an exact science. I have not been given any guarantees about the result.
- ✓ I have had ample opportunity and time to discuss my concerns with the Practice or any healthcare provider, and all my questions have been answered to my satisfaction.
- ✓ By signing below, I hereby provide my informed consent to receive PT Services as described above.

_____ _____

Signature Date

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Authorization for Use or Disclosure of Protected Health Information Form

Payment and Insurance Claims Processing & Coordination of Care

I,_____, voluntarily authorize Carpenter Physical Therapy to disclose and use the protected health information contained in ***(check one)*** ☐ my health record, or ☐ my dependent's health record, and other private information to the extent necessary for the Practice to obtain payment and submit claims on my behalf to my insurance company or other third-party payor, and to the extent necessary to coordinate care with my primary care physician or other treating provider.

Agreement & Acknowledgment

I agree and acknowledge that:

- ✓ My insurance company, or other third-party payor, may make payments directly to Carpenter Physical Therapy and assign to the Practice any medical benefits to which I may be entitled, including any benefit under Employee Retirement Income Security Act of 1974 (ERISA), in consideration for the services provided;
- ✓ If I am not the primary beneficiary of my insurer or third-party payor's policy, the Practice may communicate with the primary insured and release the information as necessary to facilitate payment.
- ✓ Information regarding schedule changes, billing, health information may be disclosed:
  - ☐ To me by: ☐ phone, ☐ voicemail, ☐ text message, or ☐ Email
  - ☐ To a family member by: ☐ phone, ☐ voicemail, ☐ text message, or ☐ Email

Signature of Party Authorizing Release

I understand I may revoke this authorization at any time by providing written notice to the Practice.

_____
Patient Printed Name

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (for dependent patients) Date

_____ _____
Witness Signature, the Practice Date

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For Patients Under the Age of 18

If you are under the age of 18, your parent or guardian must consent to our services. I, _____, am the legal parent or guardian (the "Guardian") of_____(the "Minor Patient"), and I am authorized to make health care decisions on behalf of the Minor Patient.

Therefore, as the Guardian, I acknowledge that the risks and benefits of, and possible alternatives to, these services have been explained to both me and the Minor Patient, as described in the informed consent section of this form.

After careful review of this entire form, I hereby agree on behalf of the Minor Patient and myself to be bound by it and hereby authorize the services described herein to be provided to the Minor Patient in my absence.

I further agree to the Practice's policies as provided herein.

_____ _____

Parent/Guardian Signature Date

_____ _____

Minor Patient Signature Date