Advanced Physical Therapy & Wellness

CONSENT FORM

Patient Name: _____

Please initial by each statement:

_____ I hereby consent to physical therapy treatment provided to me by Advanced Physical Therapy & Wellness, as prescribed by my physician.

_____ I understand that Advanced Physical Therapy & Wellness will bill my secondary insurance carriers.

_____ I authorize the release of any medical information necessary to process this claim.

_____ I understand and agree that I am personally responsible for all fees for services rendered by Advanced Physical Therapy & Wellness, to me or my dependants regardless of what my insurance covers. I also agree to pay, on a weekly basis, the co-pay / co-insurance portion.

_____ I authorize the use of any images taken during my treatment. I understand my approval will be obtained prior to final publication of photo(s) and will be used for marketing purposes only.

Any reduction or denial of claims by your insurance company does not relieve you of the financial obligation you have incurred for physical therapy. If you have any questions regarding your insurance, please feel free to ask any of the APT staff members.

_____ _____

Patient/Authorized Signature **Date**

Medicare Patients ONLY:

You must be discharged from any home health care services prior to initiating outpatient physical therapy. Medicare will not pay for both home health care and outpatient care at the same time.

The benefits in the Part B program have changed. It now specifies that there is a $1,900.00 limitation for outpatient physical therapy per calendar year in all settings. This translates to approximately 17 visits of physical therapy. **If your condition requires care beyond $1,900 we will be happy to discuss treatment options to encourage you to continue at our facility.**

Your present treatment plan **must have nothing to do with an automobile accident, legal case or be covered by your employer's medical policy.**

- SINCE JAN 1ST OF THIS YEAR, HAVE YOU RECEIVED PHYSICAL AND/OR SPEECH THERAPY? **YES___ NO___**
- Is this injury covered by Auto Insurance, Employer's Insurance, or a Legal Case? **YES___ NO___**

I acknowledge that I have read the above policy, and I understand that I am responsible for my 20% copayment, any deductible not met, and for notifying Advanced Physical Therapy if I have not met the above mentioned criteria.

_____ _____

Patient/Authorized Signature **Date**