# Physical Therapy Consent Form

For PT services rendered by Accelerated Sports Therapy & Fitness, Inc (AST&F).

Patient Name: _____ Date of Birth: _____
First MI Last

Address: _____
Street Address/Apt. # City State Zip

Home Phone Number: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Referring Physician: _____

1. I, the patient, (or _____, parent/guardian for the patient), do hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatments sought by myself and/or as ordered by a physician or their assistants, as defined in the Minnesota Physical Therapy Practice Act.

2. I understand that I am responsible for understanding my insurance plan's policy on co-pays, deductibles or provider information that pertain to my physical therapy treatment at AST&F.

3. I authorize payment directly to AST&F of the benefits otherwise payable to me but not to exceed the regular charges for this treatment period. If I have sought litigation due to my injury and refuse to provide adequate insurance information, I understand that I am required to pay AST&F at the time of each treatment. I also understand that if I have filed a worker's compensation claim and that claim is denied, I will then be responsible for payment of services provided at AST&F, including all charges not covered by my insurance.

4. I hereby authorize AST&F to release medical information regarding myself and my current condition to my insurance company for purpose of payment and/or quality reviews, as well as referring, consulting, treating physicians or other medical providers as needed to support continuity of care. This authorization will remain valid until revoked in writing.

5. I consent to the use of still photography and/or video analysis as a component of my physical therapy services. These will be used only as necessary for my plan of care, and I will be made aware that these photos or videos are being taken. These photos, videos tapes or CD's are part of my medical record and cannot be reproduced or used otherwise, without my written consent.

6. I authorize the use of my medical records for medical or scientific research, which allows researchers to learn new or better ways to evaluate and treat injuries or illnesses. Research results do not identify individuals by name or any other personally identifying characteristics. This authorization does not expire but may be revoked or limited by me, in writing, at any time.

7. I have seen or can receive a copy of the AST&F Notice of Privacy Practices upon request. In addition to my insurance company and referring physician, the following individuals may have access to my medical information: _____

8. I have read this form and certify that I understand its contents as of this date.

**Signature of patient or parent/guardian** **Date**

**Witness if patient is a minor** **Date**

Please See Other Side

# Patient Insurance Waiver/Payment Policies

Patient Name: _____ Date PT Treatment Begins: _____

Insurance Type:_____ Subscriber Name:_____ Subscriber Birthdate: __ / __ / ____
(ie. Blue Cross, Medica) (Policy Holder)

***YOUR INSURANCE IS A CONTRACT BETWEEN YOUR INSURANCE COMPANY AND YOU***

AST&F is unable to obtain specific details of your insurance coverage, such as deductibles, co-pays, co-insurances, your financial obligations and pre-authorization requirements, due to privacy laws. You can, however, obtain this information by calling the customer service number or checking the website of your insurance company, or by checking with your employer's Human Resources Department.

Insurances deny payment for many reasons. By checking on this information, maximum benefits will be paid by your insurance, and thereby reduce your financial responsibility. For example:

- Your plan may not cover physical therapy.
- Your plan may not cover specific treatments you need.
  (Examples include, but are not limited to, laser and iontophoresis)
- Your plan may only pay for a certain number of PT visits.
- Your plan may not pay if you fail to get the referrals and approvals required by them.
- Your plan may not pay if the information you provide is not complete, accurate or timely.

*The **estimated cost** of physical therapy care can range from **$150 for a regular visit up to $250 for the initial evaluation**.*
*Costs will vary based on the type of treatment you receive.*

I have read the above, and I understand that I must pay for services not covered by my insurance. I need to learn the rules of my insurance plan and will bring my insurance card to my first PT visit. This waiver is valid throughout my entire course of treatment, which may include many PT visits.

**Please sign one of the two below:**

I have reviewed the estimated cost of care listed above. If my insurance plan refuses to pay for any services rendered at AST&F, I will pay for them myself.

_____

**Patient or parent/guardian signature** **Date**

**-OR-**

I have reviewed the estimated cost of care. I do not wish to have the following services, because my insurance company will not cover the charges and I do not want to pay for the services myself:

Please list the specific service(s): _____

_____

**Patient or parent/guardian signature** **Date**

Please See Other Side