Heritage Health and Physical Therapy LLC

CONSENT FORM/RELEASE OF INFORMATION

Patient Name _____

CONSENT TO EVALUATION AND TREATMENT

I do hereby consent to the evaluation and treatment by Heritage Health and Physical Therapy LLC. If parent/legal guardian, I authorize Heritage Health and Physical Therapy LLC to evaluate and treat the minor patient named in the intake form while I am not present. I have been informed and acknowledge that in using the equipment and services at Heritage Health and Physical Therapy LLC, I do so at my own risk. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment. Initial _____

ASSIGNMENT OF BENEFITS

I request that payment of the Medicare/Other Insurance benefits be made on my behalf to **Wille Physical Therapy LLC DBA Heritage Health and Physical Therapy LLC** for any services furnished to me by Heritage Health and Physical Therapy LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Initial _____

FINANCIAL AGREEMENT

The undersigned agrees, whether signing as an agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the rates and terms of Heritage Health and Physical Therapy LLC. Heritage Health and Physical Therapy LLC will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment , deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility. The agent/patient agrees to submit insurance checks immediately to Heritage Health and Physical Therapy LLC that are sent directly to them. Initial _____

Medicare Patients: I understand that if I do not have supplemental insurance/s, I will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible.

Initial _____

OVER>>>

CANCELLATION POLICY

The undersigned is aware and agrees, whether signing as an agent or patient, to an out of pocket fee of $60 dollars for each scheduled appointment that is either missed without notice, or canceled without 24 hour notice. Due to our one on one/by appointment only scheduling policy, HH&PT requires 24 hour notice for canceled appointments. Initial _____

RELEASE OF INFORMATION

I authorize Heritage Health and Physical Therapy LLC to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my physician, insurance company and to the following: (*name and relationship*)

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for communication and care coordination on my behalf. Initial _____

PRIVACY PRACTICES

Heritage Health and Physical Therapy LLC has taken comprehensive steps towards the privacy and security of your personal health information (PHI). I acknowledge receipt of Heritage Health and Physical Therapy LLC's Notice of Privacy Practice (NPP), which I have received at the time of this admission or previously. Initial _____

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy if requested, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form. **The undersigned also acknowledges that s/he has been informed that Heritage Health and Physical Therapy LLC is the trade name for Wille Physical Therapy LLC.**

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Signature of Patient/Agent or Parent/Legal Guardian Date

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Clinic Rep/Witness *Revised: May 2023*