re+active
wellness and PT studio

Client Consent Form

Client: _____ D.O.B. _____

initial here:_____ CONSENT:

I consent to physical therapy, occupational therapy and wellness services at [re+active] physical therapy and wellness. By signing this form, I am acknowledging that I understand the risks and benefits of these services. I understand that I may, at times, see an increase in my symptoms. I know if I have any questions about my care, I should be sure to ask the therapist or staff about them. I know it is up to me to inform the therapist or staff about any health problems or allergies I have. I understand that I must also tell the therapist or staff about drugs or medications I am taking.

initial here:_____ INSURANCE:

I authorize the staff at [re+active] to review my insurance coverage with my insurance company. **I understand that my insurance benefits are only a quote of benefits and not a guarantee of payment. I understand that what I am quoted by [re+active] and/or my insurance company may differ from what I may owe at the conclusion of services. I understand it is my responsibility as the patient to know my insurance coverage. I authorize payment of my insurance benefits to be made directly to [re+active]. I agree to pay in full any and all charges not paid by insurance or other benefits. I understand that [re+active] cannot waive co-pays, co-insurances, and deductibles that are my responsibility.**

☐ **I certify that I am not receiving home health services and recognize that Medicare will not reimburse for home health services and outpatient physical therapy.**

initial here:_____ RELEASE OF INFORMATION (HIPAA):

[re+active] releases patient health care information for purposes of treatment, payment, or to other health care organizations. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits. I understand that I may restrict my personal health information from anyone by submitting a written request. Please see our notice of privacy practices.

initial here:_____ NOTICE OF PRIVACY PRACTICE:

I have read the [re+active] Statement of Privacy Notice and I understand that a copy of the notice will be provided to me upon my request.

initial here:_____ COMMUNICATIONS REGARDING MY ACCOUNT:

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I agree that the [re+active] or any other collection or servicing agency or agencies retained by [re+active] (collectively called agencies) to collect any money that I owe to the [re+active] may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the agencies may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the agencies may contact me using e-mail at any e-mail address I provide to the [re+active] or is otherwise associated with my account.

initial here:_____ EMAIL COMMUNICATION:

I consent for [re+active] to use email correspondence during my time of service. Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of e-mail information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct.

PHOTO AND VIDEO RELEASE:
I consent and agree for [re+active] to have the right to take photographs, digital video, or other digital recordings of me and to use these for (initial one):

___For my medical record only.

___For my medical record and educational purposes.

___For my medical record and for marketing or educational purposes.

initial here:_____ CANCEL/NO SHOW/LATE POLICY:

If you must cancel your scheduled appointment, a 24-hour notice is required.
Out of respect for our therapists and instructors, if you cancel late, or arrive greater than 20 minutes late for two consecutive appointments your appointments will be moved to our wait list.

Cancelations with less than 24-hour notice and no shows will result in a $25 fee for the first occurrence, $50 for the second and $75 for 3 or more. You are individually responsible for this fee, not your insurance company.

I certify that any and all information provided by me is true. I have read the information on the front and back of this form. It has been fully explained to me and all of my questions have been answered.

_____

Patient/Guardian Signature **Date**