FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

# PATIENT CONSENT FORM

***Please read & sign indicating you are in agreement prior to receiving treatment.***

**Regarding Insurance**
We bill your insurance company as a service to you. In order to do so we a need your insurance information including your card. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Freedom will not be responsible for mistakes made due to incomplete or inaccurate information. Services provided may not be covered and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for understanding your coverage and whether you need to be pre-certified for therapy treatment. **You are responsible for any amount that is not covered or denied by your insurance carrier.** Any balances will be considered current from the date your insurance pays its portion. You will have a thirty-day grace period to pay your portion of the services. If after thirty days we do not received payment in full from you, we reserve the right to send your account to collections. **All co-pays are due at the time of visit.** We reserve the right to refuse treatment to any patient not paying their co-pay at time of visit. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Unless discounted rates are predetermined by contractual agreement, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You hereby instruct and direct your insurance company to pay by check made out and mailed directly to Freedom Physical Therapy Services, the expense benefits allowable and otherwise payable to you under your current insurance policy as payment toward the total charges for therapy services rendered. **THIS IS A DIRECT ASSIGNMENT OF YOUR RIGHTS AND BENEFITS UNDER THIS POLICY.** A photocopy of this assignment shall be considered as effective and valid as the original.

**Workers Compensation, Accidental Injuries, Liabilities**
If you are claiming workers compensation or filing claims to a liability carrier, you must provide us a copy of your primary insurance card and a physician's referral. For Workers Compensation cases, we must have prior authorization from your employer to begin treatment. With Liability Cases, you must sign all forms relating to your case. The attorney handling your case must sign our lien form. In the event payment for your claim is denied by a workers compensation or liability carrier, we will file claims with your personal health insurance. If your claim is denied and your personal health insurance will not pay for services rendered, you will be required to pay on your account consistent with our financial policy. In the case of personal injury, you instruct and authorize your attorney to pay directly to Freedom Physical Therapy Services, any monies due on your account, the same to be deducted from any settlement made on your behalf. You agree that, in the event of a settlement, the payment to Freedom Physical Therapy will occur directly from the trust account held by your attorney before any monies are distributed directly to you. No other third party, including your attorney, should receive payment of your medical bills except Freedom Physical Therapy Services. If you do not receive a settlement or it is less than your total bill, you will personally be responsible for the balance and/or cost for all services rendered.

**Minor Patients**
A parent or legal guardian must accompany minors at time of their initial visit. The parent or guardian is responsible for full payment. If parents are separated and both legally responsible for treatment of their minor child, please provide complete information from both parents so we may bill the appropriate insurance. The parent or guardian that accompanied the minor to our office will be held wholly responsible for payment should any dispute over payment arise. For unaccompanied minors that are required to pay a co-pay at follow up appointments, a pre-authorized credit card may be used, or cash/check at the time the service will be required.

**Missed Appointments**
Unless cancelled at least 24 hours in advance by telephone, our policy is to charge for missed appointments at the rate **of $25.00 for the first appointment, $50.00 for the second appointment & $75.00 for the third and any thereafter**. Please help us serve you and others better by honoring scheduled appointments**.**

**Treatment**
You hereby consent to the rendering of a physical and occupational therapy evaluation and treatment as deemed appropriate by the treating therapist. You have the right to decline treatment at any time. Your therapist will explain your therapy diagnosis and discuss treatment recommendations with you. We strive to provide the highest quality care with minimal discomfort, however, some conditions are painful to treat. Therapy is most effective if you participate according to the plan of treatment agreed upon with your therapist.

**Medical Records Release**
You also authorize Freedom Physical Therapy to release of any information pertinent to your case to any doctor, insurance company, adjuster, or attorney involved in this case.

**Privacy Practices**
You have been offered the opportunity to review and to receive a copy of Freedom Physical Therapy's Notice of Privacy Practices with an effective date of January 1, 2003.

**I have reviewed and agree to all of the statements above:**

Patient Signature (or Parent/Guardian) _____ Date_____

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# AUTHORIZATION AND/OR REQUEST FOR MEDICAL RECORDS RELEASE

_____ _____

**Patients full name** **Date of Birth**

## Authorize & Request

_____

**Name of Party to release records**

_____

**Address**

## *Please release the following (Check One):*

**_____Medical Records** **_____MD Office Note**
**_____MRI Report** **_____CT Scan Report**
**_____X-Ray Report** **_____Films (X-Ray/CT/MRI)**
**_____Other (specify) _____**

## *Purpose of Disclosure:*

**_____ Physical/Occupational/Massage Therapist Request**
**_____Other (specify)_____**

## *Expiration:*

This authorization expires on _____. If no date is specified then this authorization will expire one year from date of signature.

## *To:*

**Freedom Physical Therapy Services**

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|---|---|---|---|
| ☐ 6908 N. Santa Monica Blvd.<br>Fox Point, WI 53217<br>Fax: (414) 352-5279 | ☐ 1235 Dakota Dr. Suite L<br>Grafton WI, 53204<br>Fax: (262) 376-5156 | ☐ 14625 W. Capitol Dr. Ste 200<br>Brookfield, WI 53045<br>Fax: (262) 790-9893 | ☐ 111 Atkinson St. Suite 2<br>Mukwonago, WI 53149<br>Fax: (262)-363-3269 |

_____ _____ _____

**Patient Signature (Parent/Guardian)** **Relationship to patient** **Date**

This authorization shall be valid for procurement of records and reports of treatment rendered either before or after the date of this document. A copy of this Authorization shall be as valid as the original.