FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

PATIENT CONSENT FORM

Financial Policy
You are responsible for any amounts that are not paid, covered or denied by your insurance carrier. Any balance not paid by your insurance carrier shall be due in full within 30 days from the date your insurance carrier pays its portion. If after 30 days you have not paid the full amount due from you, your account will be considered delinquent and may be sent to collections. We also charge a late payment fee of 12% per annum on any amounts not paid when due. 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 or with an outstanding balance.

Workers Compensation, Accidental Injuries, Liabilities
If you are claiming workers compensation or filing claims to a liability carrier, you must provide us with 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. For 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 by your personal health insurance, you will be required to pay any balance due to Freedom. 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. 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. 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. Any balances owed by you will be subject to Freedom's interest charges for patient balances.

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 are legally responsible for treatment of their minor child, please provide complete information from both parents/guardians so we may bill the appropriate insurance. 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, your account will be charged $75.00 for each missed appointment. This also includes if you do not show to your appointment.

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 authorize Freedom Physical Therapy to release any information pertinent to your case to any doctor, insurance company, adjuster, or attorney involved in your case or to anyone you designate in writing as able to receive your medical information.

Communication Preferences
I consent and state my preference to have Freedom Physical Therapy communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, treatment, appointments and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be unsecure and that there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

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 September 2017. You recognize that for the purposes for treatment, payment, healthcare operations or as permitted or required by law, you give your written authorization to Freedom to release any of your protected healthcare information.

As part of an insurance contract, Freedom is participating in WISHIN. WISHIN is a database that gathers health information to connect physicians, clinics, hospitals, pharmacies and clinical laboratories. The objective is to share your personal health information with other health care professionals who may be treating you. All participating professionals in WISHIN have access to all patient information in the database. However, each professional must state that they will only review information for patients they are treating. The health care professionals are currently in Wisconsin, Illinois, Minnesota and Iowa. At Freedom, we believe it is important for you to be aware of who has access to your personal health information.

In accordance with Wisconsin law, you are automatically enrolled in WISHIN. If you do not wish for your personal health information to be shared in this database, you can opt out. If you opt out, only emergency room physicians can still view your information. The link to opt out is: https://www.wishin.org/Portals/0/Policy/Patient%20Choice%20Form.pdf

If you would like to review additional information about WISHIN, please go to wishin.org

By signing, I acknowledge that I have reviewed and agree to all of the statements in this consent form.

Patient Name (printed) **Date**

Patient Signature

(Rev 1/1/2024)