FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

PATIENT CONSENT FORM

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

Financial Policy

You are responsible for any amounts that are not paid, covered or which are 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 under your policy. You will then have 30 days to pay the remaining balance due. 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.

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. 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 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, 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 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. 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 legally responsible for treatment of their minor child, please provide complete information from both parents 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, our policy is to charge for missed appointments at the rate **of $35.00 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 September 2017. You recognize that outside of the purposes for treatment, payment, certain healthcare operations or as permitted or required by law, you give your written authorization to Freedom to release any of your protected healthcare information.

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

Patient Signature (or Parent/Guardian) _____ Date_____

1-1-2018

FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

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

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