



## **CONSENT TO ROUTINE PROCEDURES & TREATMENTS & FINANCIAL RESPONSIBILITY**

### **CONSENT TO ROUTINE PROCESURES AND TREATMENTS:**

I consent to routine procedures and treatments at Pure Rehab Physical Therapy. I understand that I have the right to ask questions about a proposed procedure or treatment (including the identity of any person providing or observing treatment and his or her affiliation with Pure Rehab Physical Therapy) at any time. I understand the practice of physical therapy is not an exact science and diagnosis and outcomes of treatment depend upon my medical condition and may involve risks. I understand that no guarantees can be made as to the outcome of my care.

#### Financial Consent:

I assign any right I may have to receive payment from any health insurance plan or other payors for services rendered to Pure Rehab Physical Therapy and the medical professionals caring for me during my treatment. I understand I am financially responsible for all healthcare services, including amounts that are not covered by my health insurance plan or payor. I agree to respond to all requests for benefit information and complete any forms required by my insurance plan. I am responsible for understanding and following the terms of my health insurance plan. I authorize Pure Rehab Physical Therapy to submit appeals for payment, including arbitration and formal complaints on my behalf as required by my insurance company. I also understand that I am financially responsible for collection costs if my account becomes delinquent and that all delinquent accounts will bear interest at the legal rate unless prohibited by law. I understand that Pure Rehab Physical Therapy may request and use data from third parties such as credit reporting agencies in order to verify data and evaluate financial options.

For Medicare/Medicaid. Patients: I certify that the information given by me in applying for payment under Title XVII and XIX of the social security act is correct. I authorize release of any information needed act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges Pure Rehab Physical Therapy. I understand that I am responsible for any remaining balance not covered by insurance. I understand that I am also responsible for and agree to pay charges not covered by the assignments made in this section including any Medicare deductibles.

Release of Health Information: HIPAA

Pure Rehab Physical Therapy may use and disclose medical information including privileged information to physicians or other healthcare providers for the purposes of providing treatment and to payors for the purposes of payment for medical treatment. HIPAA also permits Pure Rehab Physical Therapy to use medical information for healthcare operations. I expressly authorize Pure Rehab Physical Therapy use and disclosure of my medical information as described in this section.

Consent to contact:

I expressly consent and authorize Pure Rehab Physical Therapy and any practitioner or clinical provider as well as any other related entities, agents, staff or contractors to contact me via phone, email, text message or regular mail. By providing this consent, I specifically waive any claim I may have to the making of such calls including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 USC 227. By providing a telephone number, I represent that I am the subscriber or owner and have the authority to use and provide consent to call the number. I also understand that I may revoke my consent to contact any time by directly contacting Pure Rehab Physical Therapy or by using the opt out or unsubscribe method in emails. I also understand it is my responsibility to contact the office to notify of any changes in phone number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or their representative, and that I am authorized to sign this document and accept its terms.

Signature of patient or representative\_\_\_\_\_

Relationship to patient if applicable\_\_\_\_\_

Date\_\_\_\_\_

## **Pure Rehab Physical Therapy Late Cancellation/No Show Policy**

To ensure the efficient operation of our clinic and provide the best service to all our patients, we have implemented a Late Cancellation/No Show Policy.

### **POLICY OVERVIEW:**

1. **Cancellation Notice:** We kindly request a minimum of 24 hours' notice for any appointment cancellations or rescheduling.
2. **No Show:** A "No Show" is defined as missing a scheduled appointment without prior notice.
3. **Late Cancellation Fee:** In the event of a late cancellation or now-show, a fee of \$50 will be charged to the credit card on file.

**CREDIT CARD ON FILE:** To streamline this process, we require all patients to keep a valid credit card on file. Your card information will be securely stored and will only be charged if you fail to provide adequate notice of cancellations or if you do not attend your scheduled appointment.

**EXCEPTIONS:** We understand that unforeseen circumstances may arise. Exceptions to the late cancellation fee may be considered on a case-by-case basis at the discretion of Pure Rehab Physical Therapy.

**HOW TO UPDATE CREDIT CARD INFORMATION:** Please ensure that your credit card information is up to date by contacting the front desk. We value your privacy, and rest assured, all information will be handled with utmost confidentiality and security.

**THANK YOU** for your understanding and cooperation. This policy enables us to maintain a high standard of care and accommodate all our patients.

**PRINT NAME:**

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**SIGNATURE/DATE:**

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## HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review the Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and the patient has had the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:

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Signature

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Printed Name-Patient or Responsible Party

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Date

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Relationship to patient (if other than patient)

I authorize release of my protected health information to:

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Name of authorized person

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Name of authorized person

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Name of authorized person

## Patient Information Form

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First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Sex F M Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
(circle one)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Primary Language \_\_\_\_\_

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### Appointment Reminders

Email Address \_\_\_\_\_ Sign up for Email \_\_\_ Text \_\_\_ Call \_\_\_

Phone # \_\_\_\_\_

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### Emergency Contact

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

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How did you hear about us? \_\_\_\_\_

Preferred method of instructional materials? Video link via email \_\_\_ video link via cell phone \_\_\_

Printed materials \_\_\_\_\_

Do you have any special learning needs or spiritual considerations that should be addressed for your treatment? If yes, please describe. \_\_\_\_\_

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Do you ever feel physically unsafe in your home? If yes, please describe. \_\_\_\_\_

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Do you ever have thoughts of self-harm? Yes \_\_\_ No \_\_\_ We will be happy to assist you in finding assistance if requested.

## Current Medication List

Patient Name \_\_\_\_\_

Medication (include strength) List OTC and Rx	Dosage	Frequency	Reason	Last taken

Drug allergies, if known \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY FORM**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Next MD Visit \_\_\_\_\_

Reason for Coming to Therapy \_\_\_\_\_

When did the problem begin? \_\_\_\_\_

Have you had this problem before? If yes, please explain. \_\_\_\_\_

Any treatment for this problem? \_\_\_\_\_

Have you had physical therapy before? If yes, please explain \_\_\_\_\_

Are you a smoker? Yes \_\_\_ No \_\_\_ Use smokeless tobacco? Yes \_\_\_ No \_\_\_

Could you be pregnant? Yes \_\_\_ No \_\_\_ Allergic to latex? Yes \_\_\_ No \_\_\_

Please check all the following conditions that apply regarding your medical history:

Condition		Condition		Condition		Condition	
Allergies		Anemia		Arthritis		Asthma	
Aneurysm		Alcohol Use		Blood Clots		Hi or Lo Blood pressure	
Cancer		Heart defect		Depression		Diabetes 1 or 2	
Dizziness		Emphysema		Epilepsy		Difficulty Speaking	
Fainting		Fatigue		Fibromyalgia		Frequent Falls	
Glaucoma		Gout		Head Injury		Headaches	
Hearing issues		Hepatitis		Hernia		Heart Disease	
HIV/AIDS		Incontinence		Insomnia		Kidney Stones	
Leukemia		Lupus		Liver disease		Memory problems	
Osteoporosis		Night Sweats				Mental Health issues	
Pacemaker		Scoliosis		Stroke		Metal Implants	
Seizures		Sciatica		Thyroid issue		Multiple Sclerosis	
Tuberculosis		Sickle Cell		Swelling		Shortness of Breath	
Difficulty swallowing		Peripheral Vascular Dis.		Parkinson's		Vision Problems	

Other, Please list: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_