

PATIENT CONSENT FORM

Please read and sign below -

- All information provided herein is true and correct.
- Consent to Treatment: I consent to physical therapy treatment under the prescription of my referring physician.
- Information Release: I give permission to WoMen's Physical Therapy Institute (WPTI) to release information, verbal and written, contained in my medical record, and other related information, to my physician, insurance company, rehabilitation nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons.
- Privacy of Information: I acknowledge that WPTI has made available a copy of their HIPAA Privacy Policy, located in the waiting area of the clinic. A copy may be obtained for my records by request. Information without patient identifiers may only be used for quality assurance and/or outcomes purposes (i.e.-research).
- Payment Responsibility: I expressly guarantee full payment of this account for all services rendered by the WPTI. Regardless of my quoted insurance benefits, I understand that I am fully responsible for all charges incurred. WPTI will file all claims to my insurance carrier and my insurance carrier will either: 1) reimburse WPTI directly if they are in-network with my insurance plan, or 2) reimburse me for these services and I am then responsible to remit payment in full to WPTI. If I have insurance benefits for physical therapy, I am expected to remit payment at each visit for my quoted deductible balance, coinsurance or copayment. If I do not have insurance coverage, I understand that payment is due in full to WPTI at the time of service.
- Medicare Patients: I am aware that Medicare has applied a combined 2012 annual limitation for physical therapy and speech language pathology services of \$1,880.00. I acknowledge that I am responsible for my 2012 annual deductible of \$140.00, any remaining balance after Medicare and my supplement have paid, and 100% of the charges if I exceed the \$1,880.00 annual limitation.
- Durable Goods Payment: WPTI has informed me that my insurance will not cover charges incurred for any durable goods purchased, including sales tax. I am responsible to pay all durable goods in full at the time of service. WPTI will bill my insurance for these goods and if the charges are denied, I understand that I am fully responsible for all charges incurred.
- Auto Insurance Patients: WPTI has informed me that they will not bill third-party auto insurance carriers, as they will not pay my medical bills until the claim is settled. WPTI will bill all claims to either my confirmed auto carrier and/or my health insurance for charges related to an auto accident. WPTI has informed me that it is my responsibility to inform them if my auto insurance medical benefits have been exhausted at any time during this course of treatment with WPTI. My auto insurance carrier will not inform WPTI when I reach or exceed the medical benefit. I am required to provide a copy of the letter to WPTI that I will receive at home stating my benefits have been exhausted.

X _____
Patient Signature (or Guardian if a minor) Date

Account # _____