TO THE CORE
PHYSICAL THERAPY & CONDITIONING

CONDITIONS & CONSENT

I understand that I am a patient at TO THE CORE Physical Therapy & Conditioning, LLC, receiving physical therapy, and/or conditioning, and/or wellness benefits.

Cooperation with treatment:
In order for physical therapy, conditioning and/or wellness treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy conditioning and/or wellness program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy
I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of **$50**.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment, conditioning and/or wellness services for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment, conditioning and/or wellness services have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential benefits: I may feel an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements and improve my skills and abilities as an athlete. I may also experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy, conditioning and/or wellness program, I will discuss my medical, surgical, pharmacological, or other alternatives with my physician or primary care provider.

Disclosure of Medical Records:
I authorize the following individuals to have access to my medical and billing records:

Name	Relationship
Name	Relationship

Financial and Insurance Responsibilities:
I agree to pay for my treatment(s) as indicated per insurance benefits discussed regarding any copay and/or coinsurance at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. **I understand it is my financial responsibility for the treatment rendered and if my insurance company denies payment for any procedures and/or treatments I will be responsible for the bill and must pay within 30 days.**

I have read the above information and I consent to physical therapy evaluation and treatments, and/or conditioning, and/or wellness treatment.

Print Name	Date
Patient or guardian signature	Therapist signature / Date

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PATIENT NAME: _____ **DOB:** _____

SCOPE OF OUR PRIVACY PRACTICES:

This notice describes the policy practices at TO THE CORE Physical Therapy & Conditioning. We pledge that all your health information will remain confidential at all times. This notice will tell you about the ways we may use your health information. You are receiving this notice as required by law.

We may disclose your health information under the following circumstances:

For Treatment: We may use your health information in consulting with nurses, physicians and other providers.

For Payment: We may disclose your health information to your insurance company to secure reimbursement for services rendered.

Appointment Reminders: We may disclose information about you when making or verifying your appointment, this may be on an answering machine or in the form of a letter.

Treatment Alternatives: We may disclose your health information to discuss alternative treatment options.

Business Associates: We may disclose your health information to outside business associates such as transcription services or collection agencies.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to a family member or others who may be responsible for your care.

As Required by Law: We will disclose your health information as required by state or federal law.

Threats to Public Safety: We may disclose your health information if there is a serious threat to public safety.

Public Health Risks: We will disclose your health information to prevent or control disease, to report abuse, to report problems with medications, to notify patients of recalls, or to notify a person who may have been exposed to disease or another serious medical condition.

Health Oversight: We may disclose your health information to health oversight agencies. Such activities may include audits, investigations and inspections.

Legal Issues: We may disclose your health information in response to a court order, subpoena, to locate a witness, a crime victim, or any other suspected criminal conduct.

Your Rights Regarding Your Health Information:

Authorization: We will not release your health information for any purpose not listed in this notice.

Right to Inspect Your Records: You have the right to inspect any clinical and billing data we have about you. Please not reasonable copying fees will be assessed.

Right to Amend Your Records: You have the right to amend or change your records at any time.

Right to Restrict: You have the right to ask us to restrict how we use your health information. We will consider your request; however, we are not required to agree.

We reserve the right to change this notice at any given time.

I understand that I have received a copy of the Notice of Privacy Practices for TO THE CORE Physical Therapy & Conditioning as required by HIPAA (Health Insurance Portability and Accountability Act).

I understand that only one signature per lifetime is required for any services at TO THE CORE Physical Therapy & Conditioning.

Signature: _____ Date Signed: _____

Printed Name: _____

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PATIENT NAME: _____ **DOB:** _____

FINANCIAL POLICY:

It is the philosophy of TO THE CORE Physical Therapy & Conditioning to work with and be fair with all patients when it comes to financial matters. To ensure that we maintain financial stability and can continue to provide medical services to the community and region, the following credit policies shall be enforced. If you have any questions or need for special consideration, please do not hesitate to call the office.

Payment Responsibility: The patient is ultimately responsible for all charges incurred. For minor patients, the parent bringing the minor for treatment will be considered the financially responsible party.

Assignment of Benefits: The practice will bill insurance plans as a courtesy for our patients if the patient provides the required insurance information and signs an assignment of benefits statement. It is recommended that the patient also verify physical therapy benefits with the insurance company prior to coming in for the initial appointment.

Non-Covered Services: Payment for all charges which are not covered by insurance are due and payable at the time of service. This includes any deductibles, copays and/or coinsurance and durable goods.

Third Party Litigation: The practice will not become involved in disputes arising from third party claims (i.e. automobile accidents, liability claims, etc.) with the exception of verified Worker's Compensation claims.

Uninsured Patients: When patients are not covered by insurance all incurred charges are due and payable at the time of service unless prior arrangements are made with the office.

Payment Arrangements: When a balance due cannot be paid at the time of service or when or when the balance becomes due, partial payments may be approved in accordance with credit and collection procedures. A patient financial evaluation will be required to determine appropriate payment arrangements. All information given regarding the ability to pay will be subject to verification.

Payment Methods: The following payment methods will be accepted: Cash, personal checks, VISA or Mastercard.

Return Check Policy: Any returned checks will incur a $35.00 fee that will be added to the account balance. After two returned checks, future payments must be made by cash, money order or credit card (VISA or Mastercard).

Delinquent Accounts: Please be advised, accounts that remain unpaid or delinquent may be referred to a collection agency, magistrate or attorney for further collection action in accordance with TO THE CORE Physical Therapy & Conditioning's established guidelines. This may incur additional fees above and beyond charges for medical services rendered.

Please note, in signing and dating below, you are acknowledging that you have read, understand and agree to the Financial Policy of TO THE CORE Physical Therapy & Conditioning.

Signature: _____ Date Signed: _____

Printed Name: _____

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COMMUNICATION CONSENT FORM:

May TO THE CORE Physical Therapy & Conditioning, LLC, and its employees (collectively "Clinic") send you text messages relating to your care with us?

O YES O NO

By providing your mobile number below, you understand that text messages will NOT be sent via secure, encrypted format.

OK to Call	OK to Text	PHONE:	BEST TIME TO CALL:
O	O	Home: _____	_____
O	O	Work: _____	_____
O	O	Cell: _____	_____

May we send you emails relating to your care with us and information regarding wellness and any health benefits?

O YES O NO

By providing your email address below, you understand that emails will NOT be sent via secure, encrypted format.

Email: _____

Signature: _____ Date Signed: _____

Printed Name: _____