**ALLIANT REHABILITATION & SPORTS THERAPY, PLLC**

**4504 LILAC LANE, SUITE 1, VICTORIA, TEXAS**

**361-572-0385**

**PHYSICAL THERAPY CONSENT FORM**

**PATIENT’S NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **CONSENT:** I consent to physical therapy services at Alliant Rehabilitation & Sports Therapy, PLLC. I know if I have any questions about my care, I should ask the physical therapist about them. I know it is up to me to inform the physical therapist/staff about any health problems, allergies, or medications I am taking. \_\_\_\_\_\_\_\_\_\_

2. **RELEASE OF INFORMATION:** Alliant Rehabilitation & Sports Therapy, PLLC releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits. \_\_\_\_\_\_\_\_

3. **INSURANCE:** I authorize the staff at Alliant Rehabilitation & Sports Therapy, PLLC to review my insurance coverage with my insurance company**. I understand that my insurance benefits are only a quote of benefits, not a guarantee of payment. I understand that what I am quoted by Alliant and/or my insurance company may differ from what I may owe at the conclusion of physical therapy. I understand it is my responsibility as the patient to know my insurance coverage. I authorize payment of my insurance benefits to be made directly to Alliant Rehabilitation & Sports Therapy, PLLC. I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that it is unlawful for Alliant Rehabilitation & Sports Therapy, PLLC to waive co-pays, co-insurances and deductibles that are my responsibility. For any returned check there will be a $25.00 fee added to my responsibility that will be included in my bill. If I do not pay my bill in the specified timeframe, then my balance will be sent to a collection agency and a 35% fee will be added to the unpaid balance and will be my responsibility.**  \_\_\_\_\_\_\_\_\_\_

4. **NO GUARANTEES:** I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist or supportive personnel. \_\_\_\_\_\_\_\_\_\_

5. **NOTICE OF PRIVACY PRACTICE:** I have read the Alliant Rehabilitation & Sports Therapy, PLLC statement of Privacy Practice Notice and I understand that a copy of the notice will be provided to me upon my request. \_\_\_\_\_\_\_\_\_\_

6. **CANCEL/NO SHOW/LATE POLICY:** If you must cancel your scheduled appointment, a 24 hour notice is required. If you arrive 15 minutes or more late for your appointment, your therapist may not have the time to treat you or your therapy time may be reduced. Three consecutive no shows without notification by you as a patient will result in discharge of therapy services and your referring practitioner will be notified. \_\_\_\_\_\_\_\_\_\_

7. **HAVE YOU RECEIVED ANY PHYSICAL THERAPY SERVICES WITHIN THE LAST YEAR?** □ **Yes** **or** □ **No**

8. **ARE YOU CURRENTLY RECEIVING HOME HEATLH SERVICES?** □ **Yes** **or** □ **No**

 **I understand that it will be my responsibility for any charges not covered by my insurance due to overlap of services while a patient at Alliant Rehabilitation & Sports Therapy, PLLC.** \_\_\_\_\_\_\_\_\_\_

I certify that any and all information provided by me in furtherance of my application for health care benefits are true. I have read the information on this form. It has been fully explained to me and all my questions about the form have been answered. I understand its contents.

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**Patient Signature/Date Patient’s Representative Signature/Date**

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**Witness/Date Relationship to Patient**