Atrium Physical Therapy, Inc.

Patient Name_____**Date of Birth**_____

_____**Consent for Treatment:** I do hereby voluntarily consent to Physical Therapy care encompassing evaluative and therapeutic procedures and treatment as determined as necessary and ordered by my physician. I understand and agree that I may be treated by a licensed Physical Therapist Assistant in the course of my care, and hereby voluntarily consent to care by these individuals.

_____**Authorization to Release Information:** I agree that Atrium Physical Therapy may give out written or verbal information concerning my medical records to any insurance carrier, agent, or other health care provider that is authorized to have access to these records. I hereby authorize other physicians/health care providers to release medical information to Atrium Physical Therapy.

_____ **Authorization to Pay Insurance Benefits:** I hereby request assignment of payment of all insurance benefits to be paid directly to Atrium Physical Therapy.

_____ **Financial Agreement:** I hereby agree to pay on the date of service all charges, including applicable co-payments and deductibles, that are not covered by my primary insurance for services rendered by Atrium Physical Therapy. I understand and agree that Atrium Physical Therapy will submit the claim for insurance payment to my primary and secondary insurance only, any other insurance after that will be billed by the patient. I understand that any balance not paid within thirty (30) days after the date of discharge will be considered delinquent unless financial arrangements have been made with the Client Service Manager. I understand that delinquent accounts 60 days past due will be converted to collections and that the account will be subject to an additional collections fee of 50% of the balance due.

_____ **Insurance on File:** I acknowledge that Atrium Physical Therapy, Inc. will use the insurance presented on the initial date of service for billing purposes. I understand that if my insurance changes I am responsible for informing Atrium Physical Therapy, inc.. Atrium Physical Therapy, Inc. has the right to refuse acceptance of the new insurance. I accept responsibility of charges if I fail to inform Atrium Physical Therapy, Inc. of changes in insurance before I receive treatment after the date of the new coverage.

_____**Copays / Deductibles: I understand that I am responsible for obtaining insurance Co-pay or Deductible information directly from my insurance carrier.** I understand that, when possible, Atrium Physical Therapy will assist in obtaining this information on my behalf.

_____ **Medicare:** If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, and 20%Part B Co-Insurance for professional charges. I understand that Atrium Physical Therapy will bill my secondary carrier.

_____I hereby authorize payment of Medigap/Crossover benefits to be made directly to Atrium Physical Therapy. In the event that my Medigap/Crossover benefits are paid to me, I agree to make payment to Atrium Physical Therapy for the balance due. I understand that I will receive reimbursement of any payments that exceed the balance due on my account that are made to Atrium Physical Therapy from my Medigap carrier.

_____**Tricare:** I participate in the_____Tricare Prime/_____Tricare Standard program. I understand that I am responsible for $_____ copayment per visit/_____20% of allowable charges. I understand that I am responsible for payment on the date of service.

_____**Worker's Compensation:** I understand that therapy services are payable through the Worker's Compensation Act by my employer, worker's compensation insurance carrier, or by any authorized agent of my employer or insurance carrier. I understand that therapy services are subject to medical review and approval prior to receiving recommended services.

_____**Telehealth:** I understand and agree that:

- the laws that protect the privacy and security of health information apply to telehealth.
- I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time.
- while telehealth services may be a useful an effective means to address the issues for which I am seeking treatment, in most cases these services will not replace in-clinic treatment. I understand that the evaluating therapist will explain the rationale for requiring in-clinic treatment.
- logging in to the telehealth platform for a treatment session, or contacting the therapist for a treatment session by telephone, constitutes my informed consent to receive treatment in this manner.

The undersigned certifies that he/she has read the foregoing, received a copy thereof inside your welcome packet, and is the patient or the patient's guardian, or is authorized by the patient as patient's general agent to execute the above and accept its terms. The undersigned acknowledges receipt of a copy of the Atrium Physical Therapy Notice of Privacy.

Patient/Guardian_____Date_____

Patient's Agent/ Representative_____Date_____