BodyWorks Physical Therapy
Orthopedic & Sports Rehab

Outpatient Therapy Consent Form

Name: _____

Date of Birth: _____

Consent to Receive Services

I hereby authorize BodyWorks Physical Therapy to render appropriate outpatient services to the named above. I recognize and agree that I have the right to refuse treatment or terminate services at any time.

Authorization for Emergency Medical Services

At any time while receiving services from BodyWorks Physical Therapy and in the event of any medical emergency, I authorize BodyWorks Physical Therapy or its employees/contractors to provide or obtain such medical treatment as they deem advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment.

Release of Medical Records

I hereby consent and request that copies of my therapy treatment records be provided to _____

for the period of my current start of care date to discharge date.

Medicare/Medicaid Payment Authorization

If a Medicare or Medicaid patient, I certify that the information given me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I request that payment of authorized benefits be made to BodyWorks Physical Therapy on my behalf.

Notice of Privacy Practices

I acknowledge that I have received a copy of the BodyWorks Physical Therapy Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by BodyWorks Physical Therapy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Financial Responsibility

I hereby authorize the release any medical or other information necessary to process my medical claims and to obtain payment of benefits. I authorized my insurance company, attorney or 3rd party payer to assign all payment benefits directly to BodyWorks Physical Therapy for the services rendered. I understand that I am financially responsible to BodyWorks Physical Therapy for all charges whether or not paid by my insurance. I also understand that I will responsible for any copay or deductible as defined by my insurer. The remaining account balance will become due upon completion of care according to term of repayment. I agree to pay any charges incurred for bounced checks, collection, court, and attorney fees.

Missed Visit Policy

A $40 fee will be assessed for a missed appointment unless a 24 hour notice is given. This fee will not be covered by any insurance. I have read and agree to above statements and certify that the above information given is correct to the best of my knowledge.

Patient Signature _____ Date:_____