PATIENT AGREEMENT FORM

Patient Name: _____

Permission to Treat:

I am aware of my current diagnosis and wish to be seen for physical therapy services at Wilton Physical Therapy. I understand that this care will include an evaluation, testing, and treatment. No guarantees have been made concerning the outcome of this care. _____

Patient Initials

Medical Release Authorization:

This is to certify that I,_____ , authorize Wilton Physical Therapy to release and obtain my medical records regarding my current diagnosis which includes, but is not limited to, case history, findings, diagnostic tests, diagnosis, prognosis, office notes or all pertinent data to/from any pertinent physicians, insurance companies, or any other responsible parties. This also authorizes telephone, voice-mail, facsimile or electronic data release of current medical and billing information pertaining to my current diagnosis. I understand and agree that a photocopy or facsimile of this authorization may be accepted to release/obtain information as though it were an original. _____

Patient Initials

KNOWING YOUR INSURANCE COVERAGE IS YOUR RESPONSIBILITY:

We are not responsible for incorrect information provided to us by your ins. Carrier. Please refer to our Office Policies and Procedures CANCELLATION NOTICE: 24 hours appreciated: we reserve the right to bill our charge of $50.00 for appointments not cancelled. We will not reschedule if two appointments are missed without cancellation.

BILLING: We bill electronically for most insurance companies. You are responsible for submitting bills not billed electronically to your secondary insurance carrier. PAYMENT DUE at the time of service includes deductibles, co-pays, percentage of responsibility, and any costs not covered by your primary insurance carrier. Bills not paid in full within 60 days of the time of service are your responsibility and interest may be collected at the rate of 1 % per month plus collection cost or legal assistance required for collection. (Exceptions include insurance contracts between Wilton Physical Therapy and your insurance company, for which the insurance company holds responsibility). You MUST NOTIFY Wilton Physical Therapy office staff of changes in your insurance participation, or referring physician. _____

Patient Initials

Acknowledgement of HIPAA Privacy Act:

I,_____, have received the Notice of Privacy Practices from Wilton Physical Therapy.

X_____ Date:_____

(signature)

X_____ Date:_____

(Parent or Guardian)

Having read the above information, I am aware of my responsibilities and agree to the policies of Wilton Physical Therapy and authorize Wilton Physical Therapy to furnish full details of my medical case to my physicians, attorney (if applicable), insurance carrier and also to request any reports or records pertaining to my care.

Signature:_____ Date: _____

My signature certifies that I have read and understand the aforementioned information