BE Fit Physical Therapy

CONSENT FOR TREATMENT AND BILLING FOR SERVICES

Patient Name: _____ Please initial each line and sign below:

___ I consent to physical therapy services at BE Fit Physical Therapy. If I have any questions about my care, I should ask my physical therapist about them. It is up to me to inform the physical therapist/staff about my medications and any health concerns, allergies, or questions I have regarding my care. I understand that I need to keep my physical therapist informed about any changes that occur in my health status and medications.

___ I agree to pay for services provided by BE Fit Physical Therapy. The fees for our services are based on reasonable and customary charges in this area, and will be billed to the insurance that you provide. It is my responsibility to provide accurate insurance information at the start of care, and to immediately update these insurance records with any changes. If you do not have insurance, BE Fit offers self-pay options, and requires that all charges are paid at the time of service.

___ I will be responsible for charges not covered by my insurance company including but not limited to deductibles and co-pays. I am also responsible for payment of any late cancellation charges, supplies and additional services not covered by my insurance.

___ **BE Fit's Cancellation Policy is a minimum 24 Hours Notice**. By canceling or rescheduling any appointment with less than 24 hours notice, or by not coming to a scheduled appointment, I will be subject to a **$50.00 cancellation or no-show fee**.

___ I agree to pay all statements in a timely fashion upon receipt. If I am having trouble paying my balance, then BE Fit can help to break the payments down into a payment plan of smaller increments.

My signature below indicates that I agree to all of the above initialed statements, and have been offered a copy of BE Fit's HIPAA Notice of Privacy Practices, which we abide by to ensure the confidentiality of your medical records.

Telemedicine Appointment Options:

☐ **Option 1** - I understand that my insurance does not cover for Physical Therapy telemedicine services at this time and I therefore will assume full financial responsibility for these services.

☐ **Option 2** - Please bill my insurance for my telemedicine services. BE Fit has verified payment for this physical therapy telehealth benefit under my plan, but this is not a complete guarantee of payment. I understand that if they do not cover these services, I assume full financial responsibility for payment of these services.

_____ _____

Patient / Responsible Party Signature **Date**

Progress notes will be sent to the physician offices you have provided to us, and will only be released to your insurance company if they require it for billing. If you would like to permit any other individual(s) to have access to your medical or financial record, please list their name and their role below:

Full Name	Relation (doctor, trainer, spouse, etc)

BE Fit Physical Therapy

CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION

Patient's Name: _____ DOB: _____

1. I consent to participate in telemedicine visits for physical therapy with my provider from BE Fit Physical Therapy. I have had the alternatives to a telemedicine consultation explained to me.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other staff for scheduling and billing purposes.. Staff will maintain confidentiality of any information obtained. I further understand that I will be informed of any other presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

5. In choosing to participate in a telemedicine consultation, I understand that some parts of the exam or treatment involving physical tests or assisted stretching/exercises may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In the case of an emergency during a telemedicine consultation (such as a fall or injury), I understand that the responsibility of the consulting specialist is to advise my local practitioner (PCP office or emergency medical personnel if primary care unavailable) and my listed emergency contact, and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained, and I hereby consent to participate in a telemedicine visit under the terms described herein.

_____ _____

Patient or parent/guardian signature **Date**