BE Fit Physical Therapy

CONSENT FOR TREATMENT AND BILLING FOR SERVICES

Please Initial below **Patient Name** _____

_____ I consent to receive Physical Therapy services at BE Fit Physical Therapy. It is my responsibility to provide the Physical Therapist / BE Fit staff with all information concerning my health concerns and to identify any questions I have regarding my care. I understand I need to keep my Physical therapist informed in changes in my status and inform them of any allergies, changes in drugs or medications and / or any additional medical consults or diagnoses. If I have questions about my care, I should ask my Physical Therapist about them.

_____ I agree to Pay for services provided by BE Fit Physical Therapy. The Fees for service are based on reasonable and customary charges for this area. BE Fit will bill the insurance provided. It is my responsibility to update insurance records when necessary. BE Fit offers competitively priced self-pay options. If I do not have or chose not to use my out of network insurance plan, then BE Fit asks that all balances 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, co-pays, non-authorized services that are beyond a timely filing or denials for non-medically necessary charges. I will be also be responsible for payment of any non-covered supplies or any additional costs associated with collecting overdue balances

_____ BE Fit's Cancellation policy. We ask that all appointments be cancelled or changed with a 24-hour notice or you may be subject to a $20.00 Cancellation/ No Show fee. This will allow BE Fit to try and schedule other patients who may be looking for openings or weekly care. I agree to pay any cancellation fees I may be charged.

_____ I agree to pay all statements received from BE Fit in a timely fashion. It is BE Fit's policy to subject any patient balances not paid after 120 days to a 3% interest charge. If I am having trouble paying my balance, then BE Fit can help to establish a separate payment plan. If I would like to pay deductibles or projected out of pocket cost in advance I may. In the event that any balance is less than expected on an advanced payment I would be guaranteed a refund on any overpaid amount.

_____My initials indicate that I have been offered a copy of BE Fit's HIPAA Notice of Privacy Practices. This is a policy we must abide by to ensure the confidentiality or your medical records. Your records will only be released to your insurance company if they require it. Progress notes will be sent to the Physician offices that you have provided to us. If you are over the age of 18 and would like to permit any individual to have access to your medical record or financial record, please provide a list their full name and their relation to you below:

Full Name	Relation

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**

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**