elizabethrogers
PILATES & PHYSICAL THERAPY

CLINIC POLICIES

Consent for Care

I (patient or legal guardian for patient who is minor) grant permission for licensed physical therapists at Elizabeth Rogers Pilates & Physical Therapy, PLLC to perform such examinations and therapeutic procedures as may be professionally deemed necessary or advisable for appropriate evaluation and treatment of my condition (or for that of my child if patient is a minor).

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Initial

Privacy Rights

As permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize the release of any and all medical information to my physician(s) and other healthcare providers as may be necessary for communication regarding my care. Additional persons I would like my health information to be made accessible to are noted below.

As permitted by HIPAA, I authorize the release of any and all of my medical records to my insurance company at their request. Other release is subject to my written consent.

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Initial

Financial Agreement

I understand that all treatment fees are to be paid at the time of service unless other billing arrangements are made with Elizabeth Rogers Pilates & Physical Therapy, PLLC and/or Elizabeth Rogers. We are a preferred provider with most major insurance companies. In cases where your insurance is not billed or Elizabeth Rogers Pilates & Physical Therapy, PLLC or it's physical therapy providers are not preferred providers, Elizabeth Rogers Pilates & Physical Therapy, PLLC will provide, on request, a superbill receipt that you may use to submit to your insurance carrier and/or keep for your personal records.

If my insurance company (or other responsible party) rejects payment or shows that a portion is the responsibility of the patient, I agree to make full payment. Statements are mailed monthly and payment is due on the 17th of that month unless other arrangements are mutually agreed upon. Exception will be made in cases where Elizabeth Rogers Pilates & Physical Therapy, PLLC's contract with the insurer precludes this. I understand that if I do not make full payment and have not made other arrangements with Elizabeth Rogers Pilates & Physical Therapy, PLLC or Elizabeth Rogers, PT, my account may be sent to collections without any further notice.

I request that all fees paid by my insurance company or other party be paid directly to Elizabeth Rogers Pilates & Physical Therapy or Elizabeth Rogers, PT unless I have previously paid said fees directly to Elizabeth Rogers.

All patients who have a deductible remaining will pay $100 per visit, at the time of service as a payment toward that deductible until the deductible is met. The $100 payment at time of service will pay for most, but not all of a visit. Therefore, patients will still receive a monthly bill from us for any remaining balance.

Co-pays are due at the time of service.

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Initial

Photo/Video Release

I give permission for my therapist to take photos or videos of me at anytime during my treatment to enhance my rehabilitation and track my progress.

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Initial

Cancellation/No Show Policy

If I "no-show" or cancel an appointment without providing 24 **business hours** notice I am responsible for paying the cancellation fee of $65 before further treatment is provided. This means that changes to Monday appointments need to be made the prior Friday. These charges cannot be billed to insurance.

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Exceptions for emergent situations may be made. If I "no-show" and/or "late cancel" two times, Elizabeth Rogers Pilates & Physical Therapy, PLLC reserves the right to discontinue providing your care. _____
Initial

Release of Liability

I understand that there are inherent risks associated with engaging in physical therapy. I understand that such risks include all types of physical injuries and/or illness up to and including the very remote risk of death. I hereby agree that my participation in physical therapy is strictly voluntary and I may choose not to participate or discontinue participation at any time. I agree to advise my physical therapist of any changes in my physical or mental health or condition. I hereby accept responsibility for any harm, injury or damage that may result from my participation in physical therapy. I further hereby waive, release, indemnify and agree to hold harmless Elizabeth Rogers Pilates & Physical Therapy, PLLC and/or Elizabeth Rogers, PT and all of its employees, officers, and affiliates for any claim arising out of any injury to me. I voluntarily accept and assume these risks.
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Initial

Dispute Resolution

I agree that in the event that a conflict arises between me and Elizabeth Rogers Pilates & Physical Therapy, PLLC and/or Elizabeth Rogers, PT, I will attempt to work out a resolution of such conflict informally. If resolution cannot be reached through good faith efforts, I agree to submit all claims I may have to binding arbitration.
_____
Initial

I HAVE READ AND UNDERSTAND AND AGREE TO THE ABOVE POLICIES.

Signature _____ Date_____

Printed Name _____

*For the best chance of reimbursement from your insurance carrier, we suggest that you contact your insurance company prior to your first appointment to determine your physical therapy coverage and providership stipulations.

If Patient is a minor:
I consent to the above policies and for care of my minor child _____(Name of Child)

Signature _____ Date_____

I HAVE RECEIVED, READ AND UNDERSTAND MY PRIVACY RIGHTS AND PRACTICES (HIPAA).
Signature _____ Date_____

I authorize the following persons to have access to my health information:

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