Consent for Treatment

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I authorize the staff at Physical Therapy at Thrive, LLC to undertake such treatment and procedures as deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by the staff of Physical Therapy at Thrive, LLC as to the results of treatment or interventions performed. I am advised that I have the full right to an explanation of treatments or procedures utilized including their benefits and risks as well as reasonable alternatives to the proposed therapy. I understand I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may be affected. Persistent refusal to participate or cooperate in the recommended treatment program may result in my discharge from the therapy program.

Personal Property

It is understood that Physical Therapy at Thrive, LLC shall not be liable for loss or damage to any personal items brought to Physical Therapy at Thrive, LLC during my course of treatment.

Release of Information

Upon receipt of a properly executed release Physical Therapy at Thrive, LLC may disclose all or any part of my records to any party or organization responsible for all or part of my therapy charges. Physical Therapy at Thrive, LLC may disclose all or part of my record to other health care providers including, but not limited to, hospitals, physicians and other health care providers. I further agree that Physical Therapy at Thrive, LLC may release all or any part of my record to any federal, state, or local government body when, in the opinion of Physical Therapy at Thrive, LLC such bodies may be liable for all or part of my charges in relation to my care and treatment pursuant to statute or rule.

Financial Consent

I agree to be responsible for payment of all outpatient physical therapy charges which are not covered by insurance. Deductibles, co-pays or co-insurance that is owed will be paid at the time of service unless other arrangements have been made with Physical Therapy at Thrive, LLC. I understand Physical Therapy at Thrive, LLC will bill me, my family, and/or other responsible parties for services provided that are not covered by insurance. Full and earnest attempts to collect all allowed amounts is required for all patients; however, if the patient fails to make some effort to clear or contribute to the reduction of his/her balance within 90 days, Physical Therapy at Thrive , LLC will send the balance to Bonneville Collections. This agency (Bonneville Collections) will conduct collection activities in compliance with *The Fair Debt Collection Practices Act* and other Federal, State and local laws.

I am aware that Physical Therapy at Thrive, LLC utilizes electronic check service and when I provide a check as payment, I authorize to use the information from my check to make a one-time electronic fund transfer from my account to process the payment as a check transaction. Funds may be withdrawn from my account as soon as the same day and I will not receive a check back from my financial institution. If my payment is returned due to insufficient funds, I authorize Physical Therapy at Thrive, LLC to make a one-time electronic fund transfer from my account to collect $20 as allowed by Idaho state law.

Un-insured/Un-insurable care

If I do not have insurance, do not have physical therapy benefits included in my insurance, my physical therapy benefits run out, or my insurance denies further physical therapy intervention, I may continue receiving services on an out of pocket basis. If I opt to continue services with Physical Therapy at Thrive, LLC under the above circumstances, I agree to complete the required paperwork and will pay out of pocket for those services and agree that Physical Therapy at Thrive, LLC is no longer expected to bill my insurance. I understand that in this case full payment is due at time of service. I understand that there may be a different fee structure for services under these circumstances.

Assignment of Insurance Billing

I and/or the responsible party voluntarily assign Physical Therapy at Thrive, LLC and its employees or contractors the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

Cancellation / No-Show Policy

I understand that treatment visits with Physical Therapy at Thrive, LLC represent a time that is set aside just for me. Cancellations will be made **24 hours in advance** so that other patients may have the opportunity to schedule the time vacated by my cancellation. A **$45 fee** may be applied to my account if I fail to give the required notice.

If I cancel three consecutive appointments or no-show for three appointments, I understand that my therapist may discharge me from their care and they may send the referring physician a note regarding my non-adherence to the therapy plan of care.

This authorization is deemed valid until I withdraw it in writing. I have read and fully understand it. By signing below I acknowledge that I have read, understand and agree to the Consent for Treatment, Financial Policy and Cancellation/No-Show Policy:

Patient Signature: _____ Date: _____

Printed Name: _____

The patient is unable to sign because: _____

_____

For the above reason, I hereby authorize, direct, and give consent on behalf of the patient.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Notice of Privacy Practices

As part of my health care, Physical Therapy at Thrive, LLC creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care. I understand that this information serves as a basis for my continuing care.

I understand that this information is used as a means of communicating among Physical Therapy at Thrive, LLC's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the *Notice of Privacy Practices* that provides a more complete review of information uses and disclosures. I understand that I have the right to review this *Notice of Privacy Practices* before signing this consent.

I understand that Physical Therapy at Thrive, LLC may change its *Notice of Privacy Practices* at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Physical Therapy at Thrive is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the *Notice of Privacy Practices.*

I acknowledge that I have received a copy of the *Notice of Privacy Practices* of Physical Therapy at Thrive, LLC and agree to the liability limitations explained therein.

_____	_____	_____
Signature of patient or legal representative	Date	Relationship to Patient

_____
Printed name of patient
Effective date April 14, 2013
Revised date September 23, 2013