Redefine.

Physical Therapy

Education & Consulting, LLC

Physical Therapy Policies & Procedures
Patient Agreement

Consent for Evaluation and Treatment You, possibly on the recommendation of a healthcare provider, have decided that physical therapy services may assist in the treatment of your condition. A physical therapy evaluation and treatments may include, but are not limited to, the following: observation, vital function assessment, physical examination, strength testing, balance and walk testing, sensory testing, measurements of swelling, stretching and strengthening exercises, and/or joint/soft tissue mobilization/manipulation and education.

Your therapist will discuss outcomes that might be expected for your case, but it is difficult to know how any one person might respond before therapy begins. It is your right to discuss with your therapist the potential risks and benefits involved with your treatment. Possible risks include, but are not limited to, falling, muscle or joint soreness, fatigue or shortness of breath, dizziness, a temporary increase in pain. All procedures will be thoroughly explained to you before you are asked to perform them and your therapist will take every precaution to ensure your safety. You have the right to refuse any evaluation procedure or treatment you feel will be unsafe for you to attempt.

I understand that in order for my therapy to be effective, I must follow the recommendations given to me by the therapist, including any home exercises. I must tell my therapist about any problems I am having with the program so that appropriate changes can be made.

Cancellation/No-Show Policy I understand the importance of attending PT sessions as agreed upon with my therapist, or giving at least a 24 hour notice if I need to miss an appointment. I understand that I will be charged a $75 fee if I cancel or no-show an appointment within 24 hours of the scheduled time. Late arrival to scheduled appointments of more than 30 minutes may result in cancellation/re-scheduling of appointment. Only emergencies or illnesses are excusable.

Payment Agreement Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies. You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
Out-of-Network Policy. Redefine Physical Therapy is a fee-for-service clinic. This means that Redefine Physical Therapy is not “in-network” with any private health plans. Payment is due at the time of service and we will not bill your insurance company. We can, upon request, provide receipts with diagnosis and

treatment codes which you may submit to your private insurance company. Such receipts cannot be made available if you are a Medicare beneficiary (see Medicare Policy below). We accept cash, personal checks, HSA/FSA cards, and credit cards.

Medicare Policy. If you are a Medicare beneficiary, you understand that our licensed physical therapists are not enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since the documentation and administrative processing of our services are not designed to meet Medicare's covered benefit requirements and we are not Medicare enrolled providers, our services will not be covered (paid) in full or in part, by Medicare (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider. We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider.

By choosing to receive our services after being fully informed of these facts, you are agreeing, of your own free will, that you do not want Medicare involved in payment for your physical therapy services at Redefine Physical Therapy. You agree to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled provider. You also understand that since we are not enrolled Medicare providers and our documentation and administrative processes do not meet the technical requirements for Medicare to cover the services we provide, our services are not subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts, statements, or treatment notes to Medicare, a Medicare Advantage Plan, or to any primary-payer private insurance for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

Privacy Rights. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy and we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Disclosure to Release Protected Health Information form before we will disclose your health information.

By signing this consent, I verify that:

1. The purpose, risks, and benefits of physical therapy have been explained to me.
2. I understand that I can decline any part of treatment at any time.
3. I understand the Redefine PT cancellation policy.
4. I understand all components of the payment policy.
5. I understand my right to privacy and understand the process for release of records.

Print name: _____ Date of birth: _____

Signature: _____Date:_____