CONSENT TO TREATMENT

I, the undersigned, do hereby request and consent to treatment provided by Olympic Peninsula Physical Therapy (OPPT). I understand that non-compliance with the program guidelines during the course of treatment may result in suspension of services. We treat all of our clients with respect and dignity. It is our mission to help you heal. To help maintain that healing environment our staff have the right to be free from acts or threats of disruptive behavior and/or physical violence, including intimidation, anger, hostility, aggressiveness, verbal abuse, harassment and/or coercion. If these occur, it will result in immediate termination of your session and a refusal of any and all future services. Depending on the severity of the behavior exhibited, we reserve the right to file a report with the local authorities if necessary. _____ (Patient Initials)

It is very important for your recovery that you attend all your scheduled therapy treatments. We understand that issues can arise that may cause you to be late for your appointment. We ask that you call to inform us if this occurs so that we can do our best to accommodate you. Appointment times are reserved to each client. For this reason, arriving after your scheduled appointment time may result in loss of time from your treatment so that your session ends at the scheduled time and does not cause the next client to wait.

MISSED APPOINTMENT POLICY

WE REQUIRE 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT. A $50.00 fee may be incurred after a missed appointment if proper notice is not given. If you fail to show or cancel 2 appointments, all remaining appointments may be removed from the schedule. If you wish to continue with your therapy then you must call the day of to schedule an appointment, if available. You may choose to pay a $50.00 fee to resume any advanced scheduling. _____ (Patent Initials)

TERMS OF PAYMENT

A claim will be submitted to your insurance company on your behalf. Many insurance plans have limits on therapy services, either dollar limits or visit limits. We strongly recommend that you ask your insurance company about these limits, preauthorizations/referral requirements or other restrictions. We will help you understand your benefits and help track these limits, however it is ultimately the clients responsibility to not exceed them. **CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

OPPT keeps records of the health care services we provide to you. We will not disclose your record's to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may ask to see and receive a copy of those records from our Medical Records Custodian. You may also ask to correct any misinformation. I understand that I have the right to a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand OPPT has the right to change this Notice at any time. I may obtain a current copy by contacting the clinic or the billing office or by downloading it online.

OPPT has my authorization to release billing information and/or condition information to:
☐ Myself and my insurance carrier ☐ My Spouse ☐ My immediate family ☐ My Employer ☐ Other _____

My signature below constitutes my acknowledgment that a copy of the Notice of Privacy Practices is available to me and that I have authorized OPPT to discuss my billing information and/or condition with the people above.

RELEASE OF BENEFITS AND INFORMATION

I authorize my insurance benefits to be paid directly to OPPT. I am responsible for all co-payments, deductibles, and non-covered services as determined by my insurance plan at the time of claims processing. I have read OPPT's billing policy. I authorize OPPT or my insurance company to release any information required for processing of this claim per OPPT's Notice of Privacy Practices. I consent to receive treatment as prescribed by my doctor. A copy of this authorization shall be as valid as the original.
Signature of Patient or Guardian: _____ Today's Date: _____

FOR MINOR PATIENTS

I give permission for my son/daughter/ward _____ to attend physical therapy sessions at OPPT.
Parent/Guardian Signature: _____ Date: _____