MAXICARE
PHYSICAL THERAPY & WELLNESS

2152 Randall Road, Carpentersville, IL 60110

PHYSICAL THERAPY CONSENT FORM

This disclosure is to advise you of the scope of practice for **Maxicare Physical Therapy & Wellness (MPTW) located at 2152 Randall Road, Carpentersville, IL 60110** and to document your consent for services.

Scope of Practice: I, the undersigned, hereby authorize MPTW, to perform the following procedures as necessary to facilitate my diagnosis and treatment, which include, but are not limited to:

General Diagnostic Procedures: (including but not limited to general physical exams, neurological and musculoskeletal assessments)

Soft Tissue and Osseous Manipulation: (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)

Electrical, Mechanical or Magnetic Stimulation of Acupuncture Points: Using very small amounts of electricity to stimulate acupuncture points and meridians or using mechanical or magnetic devises to stimulate acupuncture points or meridians.

I recognize the potential benefits and risks of these procedures, which include but are not limited to:

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from topical procedures, heat or frictional therapies, electromagnetic-and hydrotherapies; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression. Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.

Notice to Pregnant Women: All female patients must alert the practitioner if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. Patients with bleeding disorders or pacemakers should inform the practitioner prior to receiving treatment.

Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
Guardian/Personal Representative's Signature	Patient's Signature
Date	Date

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PCP CORRESPONDENCE CONSENT FORM

I give my permission to **Maxicare Physical Therapy & Wellness** to consult with my other health care providers regarding my health and treatment. Those health care providers I have authorized are listed below: _____ ***(initial for consent)***

Names of Physician/practitioner	Address / Location	Phone Number

Consent for Records Release:

I understand that my practitioner will abide by the Notice of Privacy Practices in accordance with the Health Information Privacy Act, a copy of which I have been given or declined. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless it is required by law and for insurance claim processing reasons. I understand that I may look at my medical record at any time and can request a copy of it, though a copy may require payment of a fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that any questions I have will be answered by my practitioner to the best of his/her ability. _____ ***(initial for consent)***

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by MPTW regarding cure or improvement of my condition. I hereby release MPTW from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
Guardian/Personal Representative's Signature	Patient's Signature
Date	Date

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HEALTH INSURANCE NON-COVERAGE NOTICE

I, the undersigned, choose to receive physical therapy services through **Maxicare Physical Therapy & Wellness** and will be responsible for any charges that are not covered by my insurance or Medicare including deductibles and co-pays.

I have been made aware that the services may be covered by co-pays and deductibles.

Client's Name: _____

Client's Signature: _____

Date: _____

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NOTICE OF PRIVACY SIGNATURE SHEET

Date: _____

Client's Name: _____ Phone Number: _____
Client's Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes:

1. Our submission of your health information to a billing agent or vendor for processing claims or obtaining payment;
2. Our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment;
3. Our submission of your health information to auditors hired by third-party payers and insurers; and
4. Other aspects of payment described in our ***Notice Of Privacy Practices***.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If you do agree, however, the restrictions are binding on us.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Maxicare Physical Therapy & Wellness.

_____ _____
Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____ _____
Signature **Date**

Source of Authority/Relationship: _____

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COMMITMENT TO PHYSICAL THERAPY

(Late, No-Show, Cancellation and Re-scheduling Policies)

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we feel it is our duty to do everything within our power to emphasize the importance of your commitment. The following policies are in place to motivate commitment.

Commitment to your appointments

- With the exception of serious emergencies your recovery depends upon attending all your appointments.
- If you need to reschedule or cancel, it is in your best interest to reschedule the missed appointment to a date as close to the cancelled or rescheduled visit as possible.
- Please Note: In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care. We will inform your physician of the fact that your service has been discontinued due to noncompliance with the prescribed rehabilitation order.

Late Policy

- If you are less than 15 minutes late and have contacted MPTW to inform us that you'll be late, you may complete the remaining time scheduled for your session, knowing that you will not receive a full session.
- If you are more than 15 minutes late and have not contacted MPTW, we hold the right to consider your appointment a "No-Show." As per the no-show policy, we reserve the right to charge you a $35 fee.

No-Show Policy

- If you schedule an appointment and do not come to your appointment, or if you arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you $35 no-show fee.
- Reminder Calls: While we offer automated reminder calls as a courtesy, ultimately, the responsibility for remembering your appointments is YOURS. If reminder calls do not go out, and you do not show up for your appointment, you will still be charged the $35 no-show fee.

Cancellation Policy

- If you need to reschedule a session, you are more than welcome to do so, as long as you provide more than 24 hours' notice before your scheduled appointment.
- Late Cancel: If you cancel within 24 hours of your appointment this is considered a Late Cancellation and we reserve the right to charge you a $35 cancellation fee.

Re-Schedule Policy

- If you need to cancel a session, you are more than welcome to do so, as long as you inform us more than 24 hours before your scheduled appointment.
- Late Reschedule: If you try to reschedule an appointment within 24 hours of your appointment this is considered a Late Reschedule and we reserve the right to charge you a $35 cancellation fee unless:
    - You reschedule your appointment to later the same day (if there is time available). OR
    - We can fill your vacated slot with another client.

Paying, Cancellation, and No-Show Fees

- Cancellation and No-Show fees are not billable to any form of insurance.
- To resume treatment following a late cancel, late reschedule, or no-show, the $35 fee will be due before your next visit. If you refuse to pay the fee, we reserve the right to turn your care back to your referring physician.

We truly do not want to have to charge you for sessions you did not attend. These policies are in place because we've found that they encourage patient compliance to their rehabilitation goals (not because we want to profit from your lack of compliance). Thank you for your understanding and participation.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

_____ _____

Patient or Guardian Signature Date