CONSENT TO MEDICAL CARE AGREEMENT

1. GENERAL CONSENTS AND ACKNOWLEDGMENTS

This disclosure is to advise you of the scope of practice for **Maxicare Physical Therapy & Wellness (MPTW)** 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 treatment. Patients with bleeding disorders or pacemakers should inform the practitioner prior to receiving treatment.

2. MY HEALTH INFORMATION

A. 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:

Names of Physician/practitioner	Address / Location	Phone Number

B. 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. 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 all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

C. ***Notice of Privacy Practices*** - As described in the ***Notice of Privacy Practices***, the use and disclosure of my Protected Health Information (PHI) for treatment purposes not only includes care and service provided here, but also disclosures of my health information as may be necessary or appropriate for me to receive follow-up care from another health professional. Similarly, the use and disclosure of my health information for purposes of payment includes:

- Submission of my health information to a billing agent or vendor for processing claims or obtaining payment;
- Submission of claims to third-party payers or insurers for claims review, determination of benefits and payment;
- Submission of my health information to auditors hired by third-party payers and insurers; and
- Other aspects of payment described in the ***Notice Of Privacy Practices***.

I agree that MPTW can and will use and disclose my health information to treat me, to obtain payment for services and to perform healthcare operations.

D. **Use of HippoScribe** - To enhance the quality and efficiency of medical documentation during my care, I understand that **MPTW** uses an AI-powered documentation tool, HippoScribe, which may record audio during patient engagements. The information collected through HippoScribe is protected under HIPAA guidelines. Audio recordings and any patient information processed through HippoScribe are encrypted and securely stored. My health information will not be used to train or improve any AI model. The use of HippoScribe is intended solely to assist with documentation and accuracy.

3. COMMITMENT TO PHYSICAL THERAPY

Adherence to the recommended number of treatments is a vital component of my progress. It is my duty to do everything within my power to emphasize the importance of my commitment. The following policies are in place to motivate commitment.

A. Commitment to appointments Except for serious emergencies my recovery depends upon attending all my 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.

B. Late and No-Show Policy

- If less than 15 minutes late and have contacted MPTW informing them that I will be late, I may complete the remaining time scheduled for my session, knowing that I will not receive a full session.
- If more than 15 minutes late and have not contacted MPTW, the appointment will be considered a "No-Show." As per the no-show policy, MPTW reserve the right to charge me a $35.00 fee.
- Appointment Reminders: While MPTW offers an automated reminder text as a courtesy, ultimately, the responsibility for remembering my appointments is mine.

C. Reschedule and Cancelation of Appointment Policy

- Rescheduling an appointment needs at least 24 hours' notice.
- Late Cancelation: Cancelations made less than 24 hours of the appointment is considered a Late Cancellation and we reserve the right to charge you a $35 cancellation fee.
- Late Reschedule: Rescheduling an appointment within 24 hours is considered a Late Reschedule and MPTW reserve the right to charge a $35 cancellation fee unless I reschedule the appointment later on the same day (if there is time available).

D. 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 the next visit.

4. FINANCIAL CONSENT AND ACKNOWLEDGEMENTS

A. I agree I am financially responsible for and agree to pay MPTW for services, supplies and use of facilities to provide my medical care and understand MPTW will charge me at the applicable rate for each location that I receive medical care. If I choose to have my health insurance reimburse MPTW for my medical care, I give permission to MPTW to bill any such insurer and update that information as necessary. I understand that insurance coverage varies and that my insurer may not pay for everything or may pay only part of my bill. If my insurer has an agreement with MPTW, then except for any applicable co-payments, coinsurance or deductibles, I will not be responsible for charges over the rate my insurer and MPTW have agreed upon. While MPTW will take reasonable steps to appeal claims denials, I understand that I am responsible for paying for services denied by my insurer.

If I choose to have MPTW bill my health insurance to pay for my treatment, I assign to MPTW my rights to receive payment from my health insurer or plan. If my insurance benefits are provided through an ERISA plan, I hereby assign, transfer and set forth all my rights, title and interest as a beneficiary of the ERISA plan to MPTW, about my treatment and care. I also appoint MPTW as my authorized representative and grant MPTW limited power of attorney to receive plan coverage information and appeal any rights to payment and healthcare benefits.

I agree to cooperate and provide information as needed by MPTW to establish my eligibility for my insurance benefits. If I claim benefits under Title XVIII of the Social Security Act (Medicare), I hereby certify that the information I provide in applying for payment of such benefits is correct, and I authorize MPTW to release to the Social Security Administration, its intermediaries or carriers, any information needed for this or any related Medicare claim. Even though I may assign my right to receive payment from my insurer, I understand and agree that MPTW may still require payment directly from me.

B. As required by the Fair Patient Billing Act, I understand:

1. I may receive separate bills from MPTW for the services provided to me. I give MPTW permission to send invoices to me via the following means:

Email Address: _____

Mobile Phone: _____

2. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan, my employer or my insurance certificate of coverage. MPTW cannot guarantee that a service will be covered under my plan.

C. If I do not have health insurance or have difficulty paying my bill, MPTW provides financial assistance options, including discounted care or interest-free payment plans.

I understand that this consent will expire three (3) years from the date that I sign it. I acknowledge that this consent will apply to all patient encounters within MPTW for the 3 years from the date that this is signed unless revoked before then. I understand that if I have previously signed a consent form with greater restrictions, this consent form replaces that prior consent, unless otherwise noted. I understand that I may revoke this consent in its entirety prior to the 3 year expiration upon written notification to MPTW. I further understand that any revocation will not apply to any actions taken in reliance of this consent and prior to the revocation.

I have read, understand and agree to this Consent to Medical Care Agreement. I have been given the opportunity to ask questions and I have no remaining questions at this time. I understand where I can access additional information. I understand that MPTW cannot honor any changes that I may make to this document.

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

www.maxicarephysicaltherapy.com
Call or Text – 224-858-5161