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 Back to You Rehab PLLC

 • P: (248) 733-4325 • F: (248) 268-7979

**CONDITIONS & CONSENT FOR PHYSICAL THERAPY SERVICES**

I understand that I am a patient of Back to You Rehab PLLC, a private, therapist owned Physical Therapy practice. Cooperation with treatment in order for Physical Therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home Physical/Occupational Therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my Physical Therapist.

Cancellation Policy: I understand that to successfully achieve the goals of treatment established by myself and my physical therapist it is essential for consistent attendance as outlined by my plan of care. I understand that three (3) no shows could result in my discharge from therapy. Furthermore, I understand that if I cancel more than 24 hours in advance I will not be charged. I understand that if I cancel in less than 24 hours in advance, I will pay a cancellation fee of $25.00. To be paid at the time of my next appointment.

Limitations: I understand that there are no guarantees regarding a cure for, or improvement in my condition. I understand that my Physical Therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. There may be times where my insurance company will withhold payment for certain services rendered but care will be taken to inform me of such circumstances prior to rendered services.

Informed Consent for Treatment: I understand the term informed consent means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential Risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential Benefits: I understand I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I can expect to gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: I understand that if I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

Financial and Insurance Responsibilities: I understand it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization that is necessary, and to obtain verification of my outpatient physical therapy benefits. I understand Back to You Rehab PLLC will call my insurance carrier as a courtesy for me but ultimately it is my responsibility to verify the information Back to You Rehab PLLC receives is accurate. If I have any questions regarding my insurance coverage I understand that I can ask my insurance carrier, my therapist, or Back to You Rehab PLLC for further assistance.

Authorization of Payment: I hereby assign my insurance benefits to be paid directly to Back to You Rehab PLLC. I understand that I am financially responsible for all non-covered services, co-pays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I understand the privacy practices (HIPAA) and how my personal health information can be used. I authorize Back to You Rehab, PLLC to release any medical information required to process any claim. I authorize Back to You Rehab, PLLC to contact me by telephone/email to remind me of my appointments. I authorize Back to You Rehab, PLLC access to my electronic medical history.

Notice of Privacy Policies: I understand that I was provided with a copy of the Notice of Privacy Policies utilized by Back to You Rehab PLLC in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) Sec. 45 CFR 160 and 164. I understand that if I would like more information about Back to You Rehab PLLC’s privacy practices or to file a complaint I can contact Back to You Rehab PLLC Attn: Privacy Officer at 2512 Rochester Road, Royal Oak, MI 48073.

I fully understand that in the event my insurance company or financially responsible party does not pay for services I receive, I will be financially responsible for payment. To avoid being held financially responsible for claims due to exhaustion of benefits, it is highly recommended that you keep track of your therapy visits throughout the year. It is also important that you let your insurance company know of your discharge from other therapy programs to avoid denial of coverage based on concurrent treatment.

**Please initial:**

\_\_\_\_ Back to You Rehab, PLLC, and their representatives, did not place any pre-retention phone calls to me or my family or undertake any in person face-to-face solicitation to be treated by the medical provider or their associates. I have visited Back to You Rehab, PLLC, of my own free will, without duress, concern, or promises of cash payment, or special treatment beyond good, hard work and diligent medical representation. I recognize there are many other health care providers available to handle my illness but choose Back to You Rehab, PLLC, and their associates to do so.

\_\_\_\_I understand that my therapist will develop an individualized Plan of Care for me of which I will be expected to complete exercises, stretching, light cardio, manual therapy, etc. In order to implement this Plan of Care, I understand I will be working with and receiving instruction from therapy technicians, therapy assistants, and therapists.

\_\_\_\_I understand Back To You Physical Therapy is a family place of health and wellness. I agree to refrain from any inappropriate or disruptive language or behavior that might upset or offend other individuals present. This includes but is not limited to disruptive cell phone use, vaping, inappropriate language, strong odors, etc. I understand that if another individual complains or comments about any of my behaviors or language I may be asked to discontinue and/or modify such behaviors.

I have read the above information and I consent to the Physical Therapy Evaluation and all subsequent treatment.

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**Patient Name** (Please Print)  **Date**

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**Patient Signature** (or Legal Guardian/Witness)