OUTPATIENT CONSENT FORM/CANCELLATION POLICY

Name_____Date_____

Dear Patient,

Thank you for trusting your medical care to Orthopedic Physical Therapy Center. We strive to render excellent medical care to you, your family and all of our patients.

In order to be consistent with this philosophy, Orthopedic Physical Therapy Center uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs.

If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone **at least 24 hours in advance**, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

1. We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is 605-725-9900.

2. If you miss an appointment or do not contact us with at least 24 hours prior notice, we will consider this to be a missed appointment and a $15.00 fee will be assessed to you. After two occurrences of missing an appointment, there will be a significant deposit required before a third treatment will be provided. This deposit will be applied to your account if you miss another appointment, otherwise returned to you upon discharge from PT.

3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

4. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

AUTORIZATION FOR TREATMENT:

Realizing that I require outpatient physical therapy care, I do hereby voluntarily consent to such health care encompassing such diagnostic procedures and medical treatment by the physical therapist, assistants or designees including consulting physical therapists, employees, and students in educational programs affiliated with as is necessary in the judgment of the physical therapist. I consent to testing for HIV(AIDS) and/or hepatitis should a healthcare worker have accidental exposure to my blood or other body substance, or as directed by my physical therapist.

RESPONSIBILITY FOR PERSONAL VALUABLES:

I acknowledge and understand I am responsible for my personal valuables (including money, jewelry, dentures, hearing aids, eyeglasses, etc.) while I am a patient at OPTC. I release OPTC from any liability for loss by theft or negligence of mine or any Clinic employee of my personal valuables.

RELEASE OF INFORMATION:
I authorize to release diagnostic and procedural information for the completion of my insurance claim. I authorize the release of clinical information to third party payers and/or their reviewing contractors to comply with preadmission reviews, continued stay reviews and retrospective review. This may include my Social Security number. Information may also be released to the Food and Drug Administration or the Department of Health and Human Services pursuant to the Safe Medical Devices Act of 1990.

ASSIGNMENT OF INDIVIDUAL BENEFITS:
Authorization is hereby granted for the direct payment to OPTC for all medical benefits payable to me. I understand I am financially responsible to OPTC for charges not covered by my insurance, and a late payment fee of 1.5% monthly will be charged, beginning with the third monthly statement. I understand I am financially responsible for all charges regardless of insurance coverage.

MEDICAL CONSENT:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I further authorize the Social Security Administration to provide my Medicare claim number and the effective date of my Medicare coverage.

_____ WITNESS

_____ PATIENT

_____ PATIENT REPRESENTATIVE

_____ RELATIONSHIP TO PATIENT

Insurance: ***(office use only)***
_____ I understand I have a $_____ copay which will need to be paid each session.

_____ I understand I have a $_____ deductible (a specified amount of money that the insured must pay before an insurance company will pay a claim) of which I have $_____ remaining. I understand I am responsible for all of the cost for these services up to my $_____ deductible at which time my insurance will pay _____% and I will be responsible for _____% of all claims. I understand that services will be processed through my insurance and the amount billed to me will be what my insurance allows for services according to their fee schedule. I understand that if my deductible has not been met I will be expected to make a payment each visit and that I will be billed for the remaining balance as it processes through insurance.

_____ Signature

_____ Date

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