PHYSICAL THERAPY & SPORTS REHABILITATION CLINIC
INDIANA STATE UNIVERSITY

1. **CONSENT FOR TREATMENT:** I hereby request and consent to and authorize my physical therapist to provide care and treatment as prescribed by my physician and/or other healthcare provider or as recommended by my physical therapist. I understand and am informed that, as in the practice of medicine, rehabilitation may have some risks. I understand that I have the right to ask about these risks and have any questions answered prior to treatment. I understand that it is my responsibility to inform my physical therapist if I experience any discomfort or pain during treatment or if I have other unresolved concerns about my treatment. I understand that response to physical therapy treatment varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury. I authorize Indiana State University Physical Therapy and Sports Rehabilitation to provide me with emergency, urgent and other medical care and treatment as needed.

   Furthermore, my physical therapist has explained to me that the majority of my treatment will take place in an open gym area. I agree to this and understand that at any time I may request to have my treatment or any discussion in a private treatment area.

2. **ATTENDANCE POLICY:** I understand the importance of attending my therapy appointments regularly and promptly to take advantage of the quality care I deserve. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I agree to provide 24 hours' notice if I need to cancel or reschedule my appointment. I understand that failure to cancel or attend an appointment, with less than 24 hours' notice will result in a cancel/no show fee of $30. I understand that if my symptoms are the result of a worker's compensation claim, Indiana State University Physical Therapy and Sports Rehabilitation is required to inform my Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments and self-pay services are due at the time of service. I understand that as a courtesy, Indiana State University Physical Therapy and Sports Rehabilitation will file medical insurance claims to my personal insurance, but that ultimately I am responsible for any amounts owed. I understand that I must provide my insurance at the time of registration. Covered benefits vary between insurance plans. Some insurance plans require pre-authorization for physical therapy services. I understand that it is my responsibility to know if my plan requires authorization and to understand the limitations and exclusions of my policy. If I have any questions regarding my coverage, I understand I can contact my plan administrator or my insurance company's customer service department. My health insurance plan may provide that all or a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance, or charges not covered or denied by my health insurance, Medicare or other programs for which I am eligible. I agree to pay such amounts which are my responsibility. I understand that I will be responsible for any balances not paid within sixty (60) days by my insurance carrier. In the event that fees are not paid as requested, a collection agency and possibly legal action may follow. I understand that I will be responsible for any additional costs associated with the collection of such fees including attorney and court costs.

4. **WORKERS COMPENSATION CLAIMS:** Indiana State University Physical Therapy and Sports Rehabilitation will file worker's compensation claims on my behalf. If a denial is received I understand that I am responsible for payment of services provided.

5. **THIRD PARTY LIABILITY CLAIMS:** I understand that if my injury is a result of a third party liability claim that I must present my medical insurance card at the time of registration and that I am responsible for all amounts due at the time of service according to my policy. I understand that I can choose not have charges filed to my medical insurance, however I will be responsible for self-pay fees prior to services being rendered.

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6. **ASSIGNMENT OF BENEFITS:** I authorize that direct payment of any benefits available to me be released to Indiana State University Physical Therapy & Sports Rehabilitation for services rendered. I agree to cooperate with Indiana State University Physical Therapy & Sports Rehabilitation and to provide such information as needed to establish my eligibility for such benefits.

7. **CONSENT FOR COMMUNICATION:** I consent to receive email communication regarding appointment updates and marketing communication from Indiana State Physical Therapy and Sports Rehabilitation. I understand that Indiana State University Physical Therapy and Sports Rehabilitation personnel may call my home or mobile number and leave a voice mail in reference to appointment reminders, insurance or billing items. I consent to the release of appointment information left in voice mail or answering machine and understand that there is privacy risk associated with these forms of communication.

8. **AUTHORIZATION FOR RELEASE OF INFORMATION:** I understand that my treatment will be documented by Indiana State University Physical Therapy and Sports Rehabilitation in electronic form. I authorize Indiana State University Physical Therapy and Sports Rehabilitation to release the necessary information to my referring healthcare provider, primary care physician, medical vendor, insurance carrier and/or its agents to expedite claim processing/payment and/or further authorization for treatment and/or medical care and/or equipment.

   By signing this form, I acknowledge that I have been offered a copy for review of Indiana State University Physical Therapy and Sports Rehabilitation's Notice of Privacy Practices which provides information on how my health information may be used and disclosed. I understand that if I have any questions regarding Indiana State University Physical Therapy and Sports Rehabilitation's Notice of Privacy Practices, I may contact the Privacy Officer at (812) 237-4150.

   X_____ **I have reviewed the HIPAA Notice of Privacy Practices and have been given the option to request a copy.**

   By signing below, I certify that I have read, understand and fully agree to each of the statements in this document. I understand that I do not have to sign and that my refusal to sign will not affect my ability to obtain treatment, nor will it affect my eligibility for benefits. However my **refusal to sign this form does not change responsibility for payment in any way.**

X _____ X _____

Patient/Guardian Signature *Date*

X _____

Printed Name

X _____

Relationship to Patient