Patient Consent to Treat, Financial Responsibility & Cancellation Policy

Name: _____**DOB:**_____**Date:** _____
Address: _____**City/State/Zip:** _____
Phone Numbers (Home): _____**(Cell):** _____
E-Mail Address: _____

Financial Responsibility:
Insurance Company: _____
Policy Holder's Name: _____ **Policy Holder's DOB:** _____
Member ID# _____ **Group #** _____

In an effort to create open communication with our patients, we would like to inform you of our office fees up front. These fees may be reduced as a result of your personal insurance. Please note that the difference in prices between Physical Therapy and Chiropractic are due to the fact that Physical Therapist works with you for thirty minutes to an hour. The physical Therapist also develops exercises specific to your individual body type and rehabilitation needs.

Prices are subject to your insurance benefits and your actual patient responsibility may vary from the cash plan prices. ***We strongly advise you to call your insurance company to verify your eligibility and coverage, or to ask any questions that you may have about your policy.*** Remember all policies are not the same, and therefore we cannot give a generalization of benefits.

Please read and sign the form below. Ask questions if there is something you do not understand.

1. **HIPAA/Release of Medical Records or as required by law:**
   - To health care providers directly involved in my care.
   - To State, Federal, and accrediting bodies for required reporting data and/or surveys for compliance
   - For Purposes of my care and for business operations

   NOTE: records are not automatically sent to your physician. They must be requested.

2. **Assignment of Benefits**
   - I authorize Knewtson Health Group to send my bills for my medical care and treatment to my insurance company and/or Medicare or Medicaid for payment, to the extent my insurance company and/or Medicare/Medicaid is required to pay the bill under terms of my insurance policy or by law.
   - I request that my insurance company and/or Medicare/Medicaid pay Knewtson Health Group and the providers who are involved in my treatment.
   - I consent to the release of my medical records by Knewtson Health group to my insurance company and/or Medicare/Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.
   - I agree to pay for charges not covered by my insurance.
   - **I understand that if I don't sign below, that Knewtson Health Group will bill me directly for payment.**

3. **Cancellations:**
   Cancellations must be made **24 hours** in advance, or there is a **$75.00 fee** assessed to you at the therapists discretion, not your insurance company, regardless of MVA or Workman's Comp status. This fee also applies to any missed appointments in which the patient fails to appear at the scheduled time of the appointment.

4. **Credit Policy & Patient Responsibility:**
   Thank you for choosing Knewtson Health Group as your health care provider. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment. We have put together the details of our credit & financial policies below. Please read carefully and sign below to begin treatment. All Patients complete our information and insurance forms.

5. **Patients with Insurance:**

Co-payments are to be paid at the time of service. The balance incurred is your responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsible in the event that your insurance company denies any claim.

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment, regardless of what your insurance company's arbitrary discrimination of usual and customary rates.

In the event that your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

6. **Patient Consent to Treat:**

"By signing this form, I consent and authorize my medical health provider to asses and treat me. I understand that my provider is available to explain the purpose of treatment, and that I have the right to refuse recommended treatment. I understand that I have the right to revoke this consent, in writing, at any time except where the Knewtson Health Group has already made disclosures in reliance to the consent. I consent to treatment(s) provided by this clinic. I understand that my condition my necessitate modifications from time to time due to the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exams(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to other perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff."

7. **Consent to Receive Text Message Appointment Reminders:**

"By signing below, I authorize Knewtson Health Group through WebPT to contact me by SMS text message to serve me better. I understand that message/data rates may apply to text messages and I know I am under no obligation to authorize Knewtson Health Group to send me text messages as part of this program. I may opt out of receiving these communications at any time by calling 952-470-8555 or initialing below."

_____ I Do **NOT** Want to Receive Text Reminders

Patient Name: _____

Patient Signature: _____ Date: _____

Authorization For Care of a Minor

"I hereby authorize the doctors in this healthcare facility and whomever they may designate as their assistant to administer treatment to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this facility. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered."

Name of Parent/Guardian_____

Signature:_____ Date: _____