Physical therapy for the body, mind and spirit

SPIRIT WINDS physical therapy

INFORMED CONSENT Standard of Practice and Code of Ethics

I have the following rights & privileges:

- The right to disclosure regarding costs and benefits;
- The right to make the decision regarding what happens to my body;
- The privilege to question risk associated with any proposed treatment;
- The privilege to request expected benefits of any proposed treatment.

I certify that all information I have provided is true and correct to the best of my knowledge.

I consent to the techniques practiced by Spirit Winds Physical Therapy.

Patient (or Guardian) Signature _____

Notice of Privacy Practices - Patient Acknowledgement

I acknowledge that I have reviewed the Notice of Privacy Practice form posted in our office which details the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient): _____

Ins Copayment/Coinsurance/Patient Responsibility/Financial Policy Acknowledgement:

It is the Patient's responsibility:

- To know his/her insurance policy. Patients should be aware of the benefit coverage, including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements and cost share information such as deductibles, coinsurance and copayments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from his/her Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay his/her co-payment at the time of service.
- To pay any deductible and coinsurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibility indicated by his/her insurance carrier.
- To facilitate claims payment by contacting his/her insurance carrier when claims have not been paid.

It is Spirit Winds Physical Therapy's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A sixty (60) day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

Insurance Co-payments & Coinsurance:

Insurance copayment and coinsurance involves an official, legal signed agreement that we (Spirit Winds Physical Therapy) have with your insurance company. **The act of dismissing an insurance copayment or coinsurance is considered Medical Insurance Fraud in California.** In order to maintain standards and ethics in our business, we **MUST** collect each insurance co-payment or coinsurance for a physical therapy visit. Those patients who refuse to pay insurance copayment or coinsurance will be discharged from physical therapy. Upon discharge, the referring and primary care physician will be immediately notified

verbally and through documentation.

Regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

I understand Spirit Winds Physical Therapy's Financial, Copayment and Coinsurance policies:

Patient Signature:_____ Date:_____

PLEASE NOTE FOR MEDICARE SUBSCRIBERS:

You will be fiscally responsible for any fees above what is covered by Medicare and/or your secondary insurance.
Patient Initials:_____

ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to:

Spirit Winds Physical Therapy
1257 Laurel Lane
San Luis Obispo, CA 93401

Any medical or professional expenses paid by my current insurance policy will go towards fees for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees and above the insurance payment or as required by my insurance policy.**

A photocopy of this Assignment shall be considered effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney for the purpose of securing payment under this policy of insurance.

Patient Name (Printed)_____ Patient Signature_____

Parent/Guardian (Printed)_____ Parent/Guardian Signature _____

MISSED APPOINTMENTS POLICY

We strive to provide our patients with excellent service and quality care. Our commitment to your well being and health is something that we at *Spirit Winds Physical Therapy* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals with you. In order to reach those goals, you must do your part. Your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all of your appointments; however, should you need to cancel, please note that we require twenty-four (24) hours notice.

If you need to cancel, please call our office and reschedule. **If you do not cancel within twenty-four (24) hours of your visit, or if you do not attend an appointment without prior notice, you will be charged $50 for the missed appointment.**

If you miss three (3) consecutive appointments, we will notify your physician and will require a new referral in order to continue your treatment.

We thank you for choosing *Spirit Winds Physical Therapy*. We look forward to working with you to help you reach your goals.

I have read and understand this policy.

Patient/Guardian Signature:_____ Date:_____