WASATCH
PHYSICAL THERAPY
& REHABILITATION
CENTER

3920 S. 1100 E. Suite #115 Millcreek, UT 84124 Voice 801-713-0610 Fax 801-713-0613

CONSENT FOR TREATMENT, FINANCIAL & COMPLIANCE AGREEMENT

Thank you for choosing **Wasatch Physical Therapy & Rehabilitation Center** as your health care facility. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical treatment. All patients must also complete the medical history and insurance form before being seen. The content of this document may not be changed.

CONSENT FOR TREATMENT: On behalf of the Patient, consent is hereby given to the facility, its contractors, medical staff, and employees to provide health care services to Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits, and it is understood that this consent may be revoked in writing at any time. It is understood that there is a risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in the outcome of health care services for which this consent is given. It is understood that therapists are separately responsible to explain what they do and, in some cases, to obtain separate consent for some services they perform.

FINANCIAL AGREEMENT: Payment of all insurance co-payments, co-insurance and deductibles are required at the time of service. Patients who have no insurance are required to pay 100% of service at the time of service. If this is impossible you will need to make payment arrangements with our office prior to any medical service. We accept cash, checks and major credit cards.

TERMS: Net 30 days from date of **invoice** unless otherwise indicated above. (If applicable, **Wasatch Physical Therapy & Rehabilitation Center** will not invoice patients until payment from insurances are received).

- **A $25.00 fee will be charged on all returned checks.**
- **Should collection of your account be necessary, Wasatch Physical Therapy & Rehabilitation Center will advise via text message or certified mail.**
- **The undersigned specifically agrees to pay all reasonable attorney fees and court cost in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 33% of the principal balance if the amount is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.**

If my account goes to collection status, I give my permission to be notified via text message:

Print Name: _____ **Signature:**_____

Relationship, of other than Patient:_____

ASSIGNMENT OF INSURANCE BENEFITS: **You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan**. **Any service provided, but not covered by your insurance company, will be your responsibility to pay.** Your insurance policy is a contract between you and your insurance company. We are not party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim. I authorize direct payment to **Wasatch Physical Therapy & Rehabilitation Center** of any insurance benefit. I agree to pay any unpaid balances on my account no more than 30 days after date of service.

RELEASE OF INFORMATION: I agree that **Wasatch Physical Therapy & Rehabilitation Center** may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices. This includes appropriate release and disclosure of my medical records in compliance with privacy provisions when necessary for my treatment and general health. While receiving treatment and/or care, **Wasatch Physical Therapy & Rehabilitation Center** has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present, my personal health information will not be disclosed unless I agree to disclosure.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII 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 request that payment of authorized benefits be made on my behalf.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and a durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore in accordance with Federal law, **Wasatch Physical Therapy & Rehabilitation Center** is notifying you that it will NOT HONOR previously signed advanced directives. If this is not acceptable to you, you must address this issue with our management prior to performing the procedure.

HIPAA PRIVACY NOTICE: I acknowledge that I have received **Wasatch Physical Therapy & Rehabilitation Center**

HIPAA PRIVACY notice and have had the opportunity to review its content. _____(patients, please initial)

Yes	No	
☐	☐	**Wasatch Physical Therapy and Rehabilitation Center Staff and Physical Therapists may leave information with my spouse or significant other.**
☐	☐	**Wasatch Physical Therapy and Rehabilitation Center Staff and Physical Therapists may leave information on my answering machine concerning appointments and personal health information.**
☐	☐	**I am between the ages of 18 and 25 and give permission for my parent or guardian to have access to my private healthcare information.**

Personal Contact: _____Relationship:_____Phone:_____

Full disclosure of my protected health information to above contact: Yes No

The undersigned signs this document either as the Patient or as the agent or representative or the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have reviewed the foregoing and have had the opportunity to ask any question I may have about the forgoing. Such questions have been answered to my satisfaction, and I indicate my understanding to what I am agreeing to by signing below, I understand that I am entitled to request and obtain a copy of this document. My consent for treatment will remain in effect unless revoked in writing.

I have the right to revoke this consent, in writing, at any time, except to the extent that Aaron C. Hall, Larry L. Baer, or the Wasatch Physical Therapy and Rehabilitation Center has taken action in reliance on this consent.

I certify that I have read this document, and am the patient, or am duly authorized to execute it and accept its terms.

Print Patient Name:_____ Date of Birth:_____

Date:	Print Name:	Signature:
Date of Birth:	Relationship, if other than Patient:	Witness to Signature: