Paula Czapla Physical Therapy, LLC

Paula Czapla PT, DPT
Physical Therapist

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CONSENT FORM/RELEASE OF INFORMATION

Patient Name: : _____

CONSENT TO EVALUATION AND TREATMENT

I do hereby consent to the evaluation and treatment by Paula Czapla Physical Therapy, LLC. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION

I authorize Paula Czapla Physical Therapy, LLC to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my (Doctor) _____
and (Insurance Company) _____ for communication and care coordination on my behalf.

I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis.

PRIVACY PRACTICES

I acknowledge receipt of the Paula Czapla Physical Therapy, LLC Notice of Privacy Practice, which I have received at the time of this admission or previously.

ASSIGNMENT OF BENEFITS

I request that payment of the Medicare/Other Insurance benefits be made on my behalf to Paula Czapla Physical Therapy, LLC for any services furnished to me by Paula Czapla Physical Therapy, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL AGREEMENT

The undersigned agrees, whether signing as an agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Paula Czapla Physical Therapy, LLC. Paula Czapla Physical Therapy, LLC will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

Cancellation Policy

The undersigned is aware and agrees, whether signing as an agent or patient, to an out of pocket fee of $25 dollars for each scheduled appointment that is either missed without notice, or cancelled without 24 hour notice. Paula Czapla Physical Therapy, LLC requires 24 hour notice for cancelled appointments.

Medicare Patients: I understand that if I do not have supplemental insurances, I will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible.

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____

Signature of Patient or Responsible Date

_____ _____

Witness Date