PHYSICAL THERAPY TREATMENT CONSENT & RELEASE OF INFORMATION

CONSENT TO EVALUATION AND TREATMENT/WAIVER

I hereby consent to the evaluation and treatment by Beyond Exercise, LLC. I am aware that it is my right to accept or refuse any treatment/services offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment/services. I understand that I will have the right to refuse to continue treatment/services at any time.

In consideration of my participation in the programs/treatment with Beyond Exercise, LLC I hereby waive for myself and on behalf of my heirs, executors and assigns, all claims of any nature arising from my participation in any programs/ treatments, and do hereby release Beyond Exercise, LLC its employees and agents, from any claims whatsoever arising from such participation. I agree to abide by all the rules for participants, and I understand the risks of such participation.

PHYSICAL THERAPY EVALUATION / RE-EVALUATION POLICY

We recognize that there may be periods of time when you do not need our services. If you are returning to Beyond Exercise after a period of 90 days for treatment of the same injury or problem, a Physical Therapy Re-evaluation is required prior to receiving care. In order to provide best practice, a Complete Care Evaluation must be performed on all patients who have not been seen in 6 months or longer for any particular condition. At that time, a new plan of care will be developed.

FINANCIAL AGREEMENT

The undersigned agrees that full payment is expected at the time of services rendered. I understand that Beyond Exercise, LLC **does not** participate with any insurance companies directly and that any physical therapy services provided will not be billed to insurance companies by Beyond Exercise, LLC. I understand that if I would like my insurance company to pay for the physical therapy services provided by Beyond Exercise, LLC I will be responsible for seeking reimbursement myself. I understand that it is not guaranteed that the services provided will be reimbursed by my medical insurance company. I am aware that fees for services provided by Beyond Exercise, LLC are subject to change without notice.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. A complete version of our privacy practices is available on our website. More information on HIPPA can be found at www.hhs.gov.

By signing, I acknowledge receipt and explanation of HIPAA.

Client Signature: ____ Date: ______________

Parent/Guardian Signature: ____

Print Name: ____

Private Practice Out of Network Notification

☐ I have private health insurance.

☐ I have Medicare.

☐ I don't have health insurance.

Beyond Exercise, LLC is considered out of network with all insurance companies. We do not directly bill insurance for the services rendered by our therapists, and payment is due at each treatment session. You may submit your receipts to your private insurance on your own in order to seek reimbursement.

In order to receive physical therapy services:

1. I understand that I am seeking services from Beyond Exercise of my own free will.
2. I know that I must pay for services out of pocket at the time of my visit.
3. I understand that I am responsible for the full payment for these services.
4. I understand that Beyond Exercise will not bill my insurance.

Due to current federal regulations, we cannot provide physical therapy services to MEDICARE beneficiaries unless all the following conditions are met:

1. I will ***NOT*** seek reimbursement from Medicare or my secondary insurance for the services I received at Beyond Exercise.

2. Neither my spouse or my legal representative shall submit claims to Medicare or my secondary insurance for the treatment I receive at Beyond Exercise.

3. I will ***NOT*** consent to the release of information regarding my treatment at Beyond Exercise to Medicare or my secondary insurance.

4. I understand that I will ***NOT*** receive receipts that provide diagnosis or treatment codes from my physical therapy session.

By signing, I acknowledge and agree to the above terms in which to receive physical therapy treatment at Beyond Exercise.

Client or Parent/Guardian Signature: ______________________________________Date: ____________

Print Name: ____