Back to Health PT, LLC, Patient Acknowledgment and Consent

Notice of Privacy Practices: Our Notice of Privacy Practices advises our patients of their rights related to their protected health information and how we may use and disclose that information. The Health Insurance Portability And Accountability Act of 1996 ("HIPPA") requires that we give our patients or their authorized representatives notice of these privacy practices. By signing this form, you acknowledge that you have been offered a copy of our Notice of Privacy Practices for review.

_____ Date:_____
Patient or Authorized Representative

_____
Relationship to Patient

Insurance, Payment, and Collections Acknowledgement: Back To Health PT, LLC, is in-network with Blue Cross Blue Shield PPO/POS and United Healthcare PPO. We are out-of network with all other insurance plans. We encourage you to become familiar with your insurance policy and understand the difference between in- and out-of-network coverage including deductibles, co-pay amounts and percent of coverage. It is your responsibility to be aware of your insurance benefits. Verification of insurance benefits in not a guarantee of payment. Deductibles, copayments and denied claims are the patient's responsibility. All co-payments are due and will be collected at time of service.

A scheduled appointment means that time is reserved for you. If an appointment is missed, or if it is cancelled with less than 24-hours notice, you will be charged an $80 fee. _____ (initial)

Back To Health PT, LLC reserves the right to send your account to a collection agency if you do not meet your financial obligation for services provided in our office. If this occurs, you will be notified prior to sending your account to collections. You will become responsible for all fees incurred during this process. If you are experiencing financial hardship, please discuss this with our office prior to initiating care, so we can work together to find a solution. By signing this form, you agree to these financial terms.

_____ Date:_____
Patient or Authorized Representative

_____
Relationship to Patient

Consent to Treatment, Authorization to Release Information & Assignment of Benefits: I hereby authorize Back To Health PT, LLC, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize Back To Health PT, LLC, to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment. I am assigning my therapy benefits to Back To Health PT, LLC, for the services in which I receive and authorize my insurance carrier to make payments to Back To Health PT, LLC, on my behalf. I acknowledge that Back To Health PT, LLC, is HIPPA compliant with regard to information sharing policies. By signing this document, I acknowledge that I have read, understand, and agree that the information contained in this document, including insurance benefits and payment requirements. I further acknowledge that any information that I have presented to verify my own identity, including my state- issued driver's license, state issued photo identification card, or my passport, and, if applicable, any information used to verify the identity of a minor beneficiary, is current, correct, and complete to the best of my knowledge.

_____ Date:_____
Patient or Authorized Representative

_____
Relationship to Patient