R.A.
PHYSICAL THERAPY & REHABILITATION
Specialists who care, Results that matter,
Helping you move through life!

Informed Consent for Physical Therapy Services

I, the undersigned, hereby agree and give my consent for R.A. Physical Therapy and Rehabilitation to furnish care and treatment considered necessary and proper in treating my condition. I understand that all anticipated risks and benefits of, and alternatives of my planned treatments will be discussed. I understand response to treatment is variable patient to patient, and it is not possible to accurately predict my response to specific modality, procedure or exercise protocol. Therefore, I am aware that the treatment may result in aggravation of my symptoms. It is my responsibility to immediately communicate any adverse or unexpected responses to therapy, and seek appropriate medical attention. As a condition of receiving physical therapy services, I agree to indemnify R.A. Physical Therapy and Rehabilitation against all claims, liabilities, losses, damages, suits, costs, and expenses (including reasonable attorney fees) relating to the physical therapy services rendered for my condition, unless such a claim is caused due to gross negligence or willful misconduct. I agree to assume all risk of property damage, injury such as strains/sprains associated with any physical therapy provided to me.

Patient Signature: _____

Disclosure of Health Information for Treatment, Payment or Healthcare Operations

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

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By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent.

Patient Signature_____

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of R.A. Physical Therapy and Rehabilitation to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims, including medical records to secure payment for Physical Therapy services rendered by R.A. Physical Therapy staff. A photostatted copy of this authorization shall be as valid as an original.

Patient Signature: _____

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I hereby authorize R.A. Physical Therapy and Rehabilitation to release and disclose all Medical History to:
Name: _____Relationship to patient: _____
Name:_____Relationship to patient: _____

VOICE MESSAGE: I authorize R.A. Physical Therapy and Rehabilitation staff to leave any voice messages regarding appointments and or medical information when medically necessary to the following phone numbers (____) _____-_____and (____) _____-_____

TEXT MESSAGING CONSENT: I consent to receiving text messages from R.A. Physical Therapy and Rehabilitation to wireless number (_____) _____-_____. Text messages to the wireless number provided will include appointment reminders.

EMAIL CONSENT: I consent to receiving email messages from R.A. Physical Therapy and Rehabilitation to the following email address _____@_____. _____ Email messages will include appointment reminders. I also understand that I have the right to terminate this authorization at any time in writing or verbally

Patient Signature: _____

Authorization for Assignment of Benefits

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of R.A Physical Therapy and Rehabilitation and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to:

R.A. Physical Therapy and Rehabilitation

Patient Signature: _____

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Financial Responsibility

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

As a courtesy, every effort will be made by R.A Physical Therapy and Rehabilitation to verify your Outpatient Physical Therapy Benefits and all services and procedures verified and pre authorized by your health insurance company.
• It is the patient's responsibility to notify R.A Physical Therapy's Billing Department if at any time there is an insurance change.

- Payment is due at each visit as determined by your Insurance plan contractual benefits
- Patient full responsibility will be determined once your claims are processed for payment by your insurance company with an Explanation of Benefits (EOB) mailed out every 30 days and it can be a forwarded balance that is different from the estimated amount collected at each time of service.
- These quoted benefits are not a guarantee of payment and are an estimate provided by your insurance provider.
- If you have a Secondary or Tertiary insurance, we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- Patient is responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage or if deemed medically unnecessary by your insurance provider.
- If you the patient have received any other healthcare interventions/muscle manipulations that utilize any of your Physical Therapy visit limitations that are still pending payment with your insurance carrier, if your insurance contract has changed during treatment/mid-treatment or after you have been discharged while previous claims are still pending with your insurance you will be responsible for the balance due for PT services.

- Other Healthcare Interventions that some insurance providers may bill under PT benefits might include the following but is not limited to: Outpatient/In Patient Physical Therapy • Occupational/Speech Physical Therapy • Chiropractic Services • Home Health Care (See Home Health Care Policy) • Muscular Manipulations
- It is the patient's responsibility to know if an Insurance Authorization is REQUIRED prior to receiving treatment and during treatment in order to continue to receive additional Physical Therapy services and that an authorization is on file with R.A. Physical Therapy and Rehabilitation. HMO and Health Maintenance Insurance plans require that an authorization is approved before a patient can be seen for treatment. Most Authorizations are not placed by R.A. Physical Therapy and Rehabilitation. Authorizations are placed by a patient's Primary Care Physician whose name will appear on the patients' Insurance card and we work with the physician's office as much as they will allow for us to assist them in this effort on your behalf.
- If your Insurance Maximum Benefit Limitations have been met/satisfied any time before/during/or after treatment with claims still pending, service amount will reflect in full charges due based on your contracted rate.
- All past due balances must be paid prior to receiving any treatment.
- If a payment is made in the form of a check and the check is dishonored or returned for any reason there will be a processing fee of $45.00 per check plus the original amount of each check.

Consent for Arbitration

I, the undersigned, hereby acknowledge that I have received and reviewed the consent form in its entirety. I had the opportunity to discuss all questions regarding the consent form, have an understanding of the consent agreement. I agree to waive the right to a trial by jury, and that legal disputes shall instead be resolved through arbitration. It is further understood that this portion of the consent is voluntary and is not a precondition to receiving therapy services at R.A Physical Therapy and Rehabilitation.

Article 2: By signing this contract I agree to have any issue of medical malpractice decided by a neutral arbitration and I am giving up my right to a jury or court trial.

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R.A. Physical Therapy is here for you! Our specialists are waiting to provide you evidence based practice care with compassion, and understanding so that you can return to moving pain free!

Patient Signature: _____

Print Name: _____

Date: _____

1537 South La Cienega Blvd., Los Angeles, CA 90035