Consent to Treatment: Authorization to Release Information , Statement of Financial Responsibility

Patient Name:_____ Date:_____

Renew Physical Therapy & Pilates, LLC acknowledges and appreciates the confidence you have shown in choosing us to provide your physical therapy needs. Our office is committed to providing you a quality one-on-one 55 minutes appointment with a skilled, Colorado licensed physical therapist. We are an out-of-network physical therapy provider, meaning we do not contract with any insurance companies including Medicare, Medicaid and private insurance companies. The services you have entered into with Renew Physical Therapy & Pilates, LLC implies a financial responsibility. You are ultimately responsible for payment of your bill. If your account is not paid in full and is sent to a collection agency, any fees incurred in collecting your unpaid balance will be your responsibility.

I have read the financial policy of Renew Physical Therapy & Pilates, LLC for providing rehabilitation services to the above named patient. I attest to the information provided being accurate and true. I agree to pay Renew Physical Therapy & Pilates, LLC the full and entire amount of all bills incurred by me or the minor I am responsible for.
Signature:_____ Date:_____

I acknowledge that the *Notice of Privacy Practices* and a link to the *Notice of Federal Civil Rights and Health Insurance Portability and Accountability Act of 1996* are posted onsite at Renew Physical Therapy & Pilates, LLC located at 8182 S. Holly St, Centennial, CO 80122 where I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.
Signature:_____ Date:_____

Consent of Treatment and Authorization to Release Information. I am aware of my diagnosis and voluntarily consent to have Renew Physical Therapy & Pilates, LLC through its licensed and certified personnel, provide evaluation and treatment as prescribed by my physician and/or recommended by my licensed physical therapist. I understand that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand I have the right to ask questions at any time during my rehabilitation care.
Signature:_____ Date:_____

I acknowledge that this is a cash-based physical therapy practice. If I choose to self-submit paperwork to my private insurance company, automobile claim or worker's compensation claim, I will inform my therapist of this **prior** to needing documentation, CPT and ICD-10 coding, and an itemized billing statement. I agree to pay the full posted physical therapy service rate at Renew Physical Therapy & Pilates.
Signature:_____ Date:_____

Patient Information Consent Form (HIPPA)

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist at Renew Physical Therapy & Pilates, LLC. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Patient Information Consent Form (HIPAA Health Information Portability & Accountability Act)

I have read and fully understand Renew Physical Therapy & Pilates, LLC's Notice of Privacy Practices. I understand that Renew Physical Therapy & Pilates, LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Renew Physical Therapy & Pilates, LLC will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Renew Physical Therapy & Pilates, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Renew Physical Therapy & Pilates, LLC has 30 days to respond to my request. Link to HIPPA: Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Release of Information

I hereby authorize the release of information to individuals listed below. Designated Individuals Authorization I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below. Authorized Designees:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I have read and understand the above consents, release of information, and designated individuals authorization above.

Patient Signature _____ Date_____