HAUSMANN
PHYSICAL THERAPY

Patient Information Practices and Consent

Consent to Treatment

I hereby agree and give my consent to Hausmann Physical Therapy to furnish appropriate rehabilitative care and treatment as considered necessary by my physician and/or recommended by my physical therapist. I understand that benefits and possible risks to all interventions will be explained, and I have the right to ask and have any questions answered prior to receiving any treatment.

Assignment of Benefits

I hereby authorize my insurance carrier(s) to directly pay Hausmann Physical Therapy for physical therapy services rendered. I understand that my insurance policy is a contract between my insurance company and myself. Hausmann Physical Therapy is not a party to that contract. I understand and agree that I am financially responsible for any charges not covered by my insurance including deductible, co-insurance, and/or co-payment amounts. In the event of default, I agree to pay collections costs and reasonable fees as may be required to obtain collection of my account.

Liability Claims and Auto Accidents

I understand and agree that it is my responsibility to provide Hausmann Physical Therapy with billing information pertaining to a liability claim, auto accident, or legal case when another party is responsible, or if I have an attorney acting on my behalf.

Workers' Compensation

If my injury is the result of a work accident and a workers' compensation claim has been initiated, I agree to provide Hausmann Physical Therapy with the employer information, representative, claim number, and carrier to ensure payment of the account.

Cancellation, Late Cancellation and No-Show

If cancellation is necessary, we require that you call at least 24 hours in advance. If calling outside of normal business hours, you may leave a detailed voicemail message. We will return your call as soon as possible.

A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a $25 missed appointment fee. I understand that insurance companies do not reimburse for missed appointments and any fees resulting from missed appointments are my responsibility.

Payment and Collections

Hausmann Physical Therapy will impose an interest fee of 16% for any balance over 60 days and will not carry balances over 90 days. I understand and agree that if my account reaches 90 days past due and I have not contacted Hausmann Physical Therapy to make payment arrangements, my account will be turned over to a collection agency.

Uses and Disclosures of Health Information

I hereby authorize Hausmann Physical Therapy to use my personal health information primarily for treatment, obtaining payment, internal administrative activities, and evaluating the quality of care that they provide. They may also disclose my personal health information, without my consent, for public health purposes, auditing, emergencies, and when required by law. In any other situation, Hausmann Physical Therapy will obtain my written authorization prior to disclosing any personal health information including general, medical, mental health, and HIV/AIDS information. I understand that I may withdraw my consent at any time.

Notice of Privacy Practices

I have been given the opportunity to read, review and receive a copy of the Notice of Privacy Practices and I understand its contents. I understand that Hausmann Physical Therapy has the right to change its Notice of Privacy Practices and I have the right to request a current copy at any time.

By signing below, I certify that I have read, understand, and fully agree to each of the statements in this document.

Patient/Guardian Signature: _____ Date: _____