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**PATIENT CONSENT FORM**

**Consent to Physical Therapy Evaluation and Treatment**

\_\_\_\_\_**(initial)** I hereby consent to evaluation and treatment (onsite and virtual) by the therapists at North Born Physical Therapy, Corp.

\_\_\_\_\_**(initial)** I agree that a physical therapist or physical therapist assistant student may assist in my care.

\_\_\_\_\_**(initial)** I consent that information regarding my care may be communicated via voicemail/text and/or email.

\_\_\_\_\_**(initial)** I consent to being photographed or videotaped for the purpose of patient education, instruction, and development of a home exercise program. I am aware that media specific to my plan of care will be placed in my medical record as protected health information and only disclosed to me. Media will not be disclosed further without my consent

**Statement of Patient Financial Responsibility**

North Born Physical Therapy Corp is pleased to be your physical therapy provider. The services you have elected to receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for services provided. As a courtesy, we will verify your primary insurance carrier on your behalf. However, you are ultimately responsible for payment. We encourage you to call your primary and secondary insurance providers to verify any responsibility you may have in receiving physical therapy services at our location. It is your responsible to notify North Born Physical Therapy Corp, of any changes to your insurance plan. It is your responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. These payments are due at the time of service. You are also responsible for any amount not covered by your insurance carrier. If your insurance carrier (including Workers Compensation and Motor Vehicle) denies any part of your claim, or if you elect to continue services past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to North Born Physical Therapy Corp, and I authorize my insurer to pay the full and entire amount of the bill for the above-mentioned patient. I will assume responsibility for any remaining balance and permit this amount to be charged to my card on file.

\_\_\_\_\_ **(initial)**

**Patient Information Consent Form (HIPAA)**

I have read and fully understand North Born Physical Therapy Notice of Privacy Practices. I understand that North Born Physical Therapy 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 information is used and disclosed for treatment, payment, and administrative operations. I also understand that North Born Physical Therapy will consider requests for restrictions on a case-by-case basis but is not required to oblige such requests.

\_\_\_\_\_ **(initial)**

**Release of Information**

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization be used in place of the original.

\_\_\_\_\_ **(initial)**

**Designated Individuals Authorization**

I authorize North Born Physical Therapy, to disclose my health information that is directly related to my current treatment to the individual(s) listed below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Individual(s) Relationship to Client

**No Show Policy**

Please call our office if you are unable to attend your scheduled appointment. Failure to call or show for an appointment will result in a $25 No Show fee.

\_\_\_\_\_ **(initial)**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Printed Name Client’s Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Representative Relationship to Client

(if patient is a minor, or if authorized by patient)