primetime
PHYSICAL THERAPY

Dry Needling • Vertigo • Spine & Sports Rehabilitation • Pediatrics • Pelvic Health • And more!
Email: care@primetimept.com
www.primetimept.com

Patient Agreement

Consent for Treatment: I have a condition requiring physical therapy intervention, and consent to the delivery of such care. I understand that my medical care and treatment may be provided by a physical therapist or physical therapist student intern. In order to improve my physical condition in regards to pain, range of motion, strength or another type of physical impairment, I consent to enter Primetime Physical Therapy program for evaluation and treatment. I request and authorize the licensed staff of Primetime Physical Therapy to render treatment, and to perform appropriate procedures that my referring provider may deem reasonable and necessary for my diagnosis. I understand that my physical therapy care and treatment may be provided by a physical therapist or physical therapy assistant. I am aware that there are certain risks involved with a physical therapy program. Every effort is made to minimize my risk by continuous assessment of my condition throughout my therapy. I will inform my therapist of any changes in my medical condition, or medications, as they may necessitate change in my therapy program. I will stop any procedure or activity and inform my therapist of any symptoms of pain, fatigue, shortness of breath, dizziness or nausea that may develop during my treatment.
_____ **(initials).**

Privacy Notice Acknowledgement: As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby acknowledge that I have had the opportunity to review a copy of Primetime Physical Therapy's "Notice of Privacy Practices". I understand that I am responsible to read this Notice and notify Primetime Physical Therapy, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. Primetime Physical Therapy has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times. I am aware that Primetime Physical Therapy has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains. Primetime Physical Therapy will provide me with a copy of its most recent Notice upon my request.
_____ **(initials).**

Requirement to Provide Proof of Current Insurance and Obtain Referral: I understand that it is my responsibility to provide Primetime Physical Therapy with a copy of my current insurance card(s) and to obtain a referral from my Primary Care Physician's office (if required by my insurance or past the 21st day Florida law). If I do not have insurance, I will be considered a Self-Pay patient and I am financially responsible for the total amount of the services provided. I will notify Primetime Physical Therapy immediately upon any changes in my insurance. _____ **(initials).**

Insurance Waiver: I understand that if I do not have a copy of a current insurance card and valid referral, if required, Primetime Physical Therapy is not obligated to see me, but if I still wish to be seen, I can be seen as a "Self-Pay" patient. I agree that neither Primetime Physical Therapy nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance. _____ **(initials).**

Payment: Co-payment is due on each day services are rendered. We accept most major credit/debit cards or checks. There is a $20.00 charge for all returned checks. When an account has received two returned checks, it will automatically be placed on a "card" only status. _____ **(initials).**

Assignment of Benefits: I hereby authorize and assign all payments and/or insurance benefits for therapy services rendered to the patient, directly to Primetime Physical Therapy. I hereby authorize Primetime Physical Therapy to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan. _____ **(initials).**

Appointments/Cancellations: We typically see patients by appointment. Please call ahead if you think you will be late. We appreciate 24 hours notification of cancellations. You may e-mail us or leave a message on voicemail if you are calling after hours. In the event you **cancel** an appointment with less than **24 hour's notice**, or **"no show"** for a scheduled appointment, you will incur a **$40 fee** for each missed visit that will be collected upon your next appointment (**$65 fee for PELVIC FLOOR**). If there are 3 consecutive lapses in scheduled attendance you will be removed from the Therapist's schedule & require a new patient referral in order to resume visits.
_____ **(initials).**

Attire: For access to particular body parts being treated, loose fitting clothing is recommended. If your evaluation includes a diagnosis that involves an assessment of the pelvis and/or pelvic floor muscles, this may require you to change clothing and wear a gown. An example of this might be evaluation and treatment for the diagnosis of lymphedema or urinary incontinence. _____ **(initials).**

Adult Supervision: Those under the age of 17 receiving treatment at our facility must be accompanied by a parent or legal guardian during each physical therapy appointment. _____ **(initials).**

Other Information: I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records, not covered by my insurance plan. _____ **(initials).**

By signing this agreement, I acknowledge that I have read, understand and agree to the above terms and conditions

Patient Signature;_____ Date:_____

Staff/Witness Signature:_____Date:_____