PARKWAY
PHYSICAL THERAPY

APPOINTMENT AND CANCELLATION POLICIES

Patients are seen by appointment only and therefore it is advisable for you to schedule the full duration of your referral as far in advance as possible. If you do need to cancel, we ask that you call us before closing hours the day prior to your scheduled appointment. If you need to cancel after hours, please leave a message on our answering machine. Any missed appointments may result in a $70 cancellation/no show fee.

INFORMED CONSENT FOR CARE AND TREATMENT

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. You are expected to fully cooperate with the evaluation and treatment program. All individuals will be accorded impartial access to treatment regardless of race, gender, national origin, disability, health status, religious, age, sexual orientation, or sources of payment for care.

Response to physical therapy intervention varies from person to person so it is not possible to predict your response to a specific modality, procedure, or exercise protocol. Parkway Physical Therapy cannot and do not guarantee what your reaction will be to a specific treatment, nor can it guarantee that the treatment will help resolve the condition for which you are seeking treatment. Potential benefits of treatment may include an improvement in my symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility, and endurance in movements and a decrease in pain or discomfort. However, there are potential risks that the physical therapy treatment may cause: you may experience an increase in your current level of pain or discomfort or result in aggravation of existing systems, pain, or injury. It is very important for you to promptly provide any updates about your medical condition(s) and to communicate with your treating physical therapist throughout your treatment.

You may decline any part of your treatment at any time before or during treatment if you feel any discomfort or pain or have any other unresolved concerns. You may ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results, and you may discuss the potential risks and benefits involved in your treatment.

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. You understand that the physical therapist provides a wide range of services, and you will receive information at the initial visit concerning the proposed treatment and options available for your condition.

By signing below, I have read the appointment policies and this consent form and understand the risks involved with physical therapy care and treatment. I voluntarily assume all of the foregoing risks and accept full responsibility for any loss, property damage, illness or exposure to illness, or personal injury, including death, that may be sustained by me or my property, as a result of my receiving such physical therapy care and treatment. I hereby give consent for Parkway Physical Therapy to furnish such care and treatment considered necessary and proper in treating my physical condition.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian must sign if Patient is a Minor.

Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____

For Questions: 800 Howe Ave, STE 400, Sacramento, CA 95825; 916-900-8758; info@parkwaypt.com

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RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

All information provided herein is true and correct. I give permission to Parkway Physical Therapy to release/obtain information, verbal and written, contained in my medical record, and other related information, to/from my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related person, as needed. By signing below, I authorize direct payments to Parkway Physical Therapy for services provided.

PAYMENT AGREEMENT

In consideration for the services rendered and to be rendered to the above-named patient by Parkway Physical Therapy, I expressly guarantee payment of the account and agree to pay any charges left unpaid in whole or in part by the insurance company. The patient is ultimately responsible for account totals and balances. The information below is provided to you only as a summary of benefits and is not a waiver of your payment guarantee or any explanation of your benefits. Patients must contact their insurance company for full "disclosure" of benefits. Please notify us if at any time there is a change in your insurance eligibility and/or benefits.

Please be advised:

Worker's Compensation patients, the above payment terms do not apply for those patients that are covered under worker's compensation. However, be advised as a worker's compensation patient that you may be held responsible for your charges in the event that your claim is disputed and/or denied.

Medicare patients, you may not access Home Health Agency Benefits and attend our clinic during the same period of time. Due to Medicare requirements, it is your responsibility to see your physician and provide a new referral to our office as required (usually 30 to 60 calendar days). If we do not receive a new referral from your physician as required, Medicare may deny payment of services and you could be financially responsible for therapy provided outside of the referral dates or we may be unable to continue treatment until a new referral is received.

Auto Insurance patients, your insurance does not usually disclose the amount of medical allotment you have and therefore it is your responsibility to keep track of all medical payments from other healthcare providers.

Estimated Insurance Benefits: _____

Estimated Patient Payment: _____

By signing below, I agree to the release of information/assignment of benefits provisions above and these payment terms. I have read and understand that I am ultimately responsible for payment of my account (including any deductible or co-payment amount due at the time of service) and for any and all account balance not paid by my insurance company and that the insurance benefits above are estimates only. After 90 days, any balance not paid by insurance will become my responsibility.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian must sign if Patient is a Minor.

Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____

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Authorization to Utilize Text Messaging and Emailing

I agree to the following forms of communication from Parkway Physical Therapy:

Email: _____YES _____NO - Appointment Reminders Only _____

Text: _____YES _____NO - Appointment Reminders Only _____

Voicemail: _____YES _____NO

I consent to Parkway Physical Therapy speaking with the following individuals regarding my appointment(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian must sign if Patient is a Minor.

Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT AND PATIENT CONSENT

I have read and fully understand Parkway Physical Therapy's Notice of Privacy Practices. I understand Parkway Physical Therapy is permitted by law to use or disclose my personal health information for the purposes of carrying out treatment or payment. I understand that I have the right to request restrictions regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Parkway Physical Therapy will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Parkway Physical Therapy's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by modifying the practice in writing at any time.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian must sign if Patient is a Minor.

Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____