AUTHORIZATION TO TREAT I voluntarily consent to therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize Crossover Physical Therapy to provide such treatment. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION. I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES RENDERED.**
Initials ______

PAYMENT AUTHORIZATION I understand that all balances designated as 'the patient's responsibility' such as co-insurances, co-payments and deductibles are due and payable to Crossover Physical Therapy. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. As part of working with my insurance carrier, I recognize that Crossover Physical Therapy may be provided with information about my insurance coverage, and that on occasion Crossover Physical Therapy may share some of this information with me. However, I understand that Crossover Physical Therapy is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. This is not a guarantee of benefits. **Initials ______**

INSURANCE BENEFITS ASSIGNMENT I authorize that the payment of my insurance benefits be made directly to Crossover Physical Therapy for all services delivered; if I am paid directly, I will promptly pay Crossover Physical Therapy all monies paid to me. **Initials ______**

HIPAA PRIVACY POLICY My signature below indicates that I have been given the Notice of Privacy Practices for Crossover Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Crossover Physical Therapy to release any of my protected healthcare information. **Initials ______**

CANCEL/NO SHOW POLICY We ask that if you are unable to keep your appointment, that a 24-hour notice is given. We do understand emergency situations may arise and just ask that you call as soon as possible. Upon 2 consecutive No Shows, all future appointments will be cancelled, and we will require same day visit scheduling. You may be charged $65 if you cancel less than 24 hours prior to your appointment. **Initials ______**

RECORD RELEASE I am aware that Crossover Physical Therapy may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care. **Initials ______**
I would like Crossover Physical Therapy to disclose my Protected Health Information to individuals other than those listed above. **YES NO** If Yes, you must complete an Auth to Release PHI form.
REMINDER CALLS As a service to patients, we may provide appointment reminder calls and other calls (ie. Weather closure) that may be placed using a pre-recorded message. By providing your number, you consent to receive such calls. **Initials ______**

Phone ______________________Text ________________________Email ________________________________

Date______________Patient Name ____

Signature of patient/patient representative ____

If applicable, patient representative's name & relationship ____

REVIEW AND INITIAL BELOW ONLY IF APPROPRIATE

MEDICARE PATIENTS ONLY Are you currently, or in the last 30 days, have you received any type of Home Health Services, therapy from a home health care agency, transitional care facility, or nursing home? __ **YES** **NO ___**

If YES, we cannot treat you until you have been discharged. Medicare will not pay our services. You may request Medicare Cap information. **Initials**

SELF REFERRAL OR OUT OF STATE REFERRAL I understand that if I have been referred by a physician who is not licensed in the state of MN <u>and I am being treated at a clinic in MN</u>, I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a physician who is licensed in the state of MN. The same 90-day rule pertains if I have not been referred by a physician and I am self-referring. **Initials____**

PAYMENT AUTHORIZATION – Cash Based- Your services will not be billed to your insurance company or do not qualify for coverage. Charges must be paid in full at the time of service in order to receive the prompt pay discount. The amount charged is determined by the case's complexity. Cost of the evaluation is $148.00 and follow up is $105.00. If a supply or orthotic is issued, there will be an additional charge. I do not want my services billed to an insurance company and will not do so myself.__ **Initials____**