How can we say hello?		
First Name:	Last Name:	Date of Birth & Age:
Street Address:	City/State:	Zip Code:
Phone Number:	Can we leave a voicemail? Text?	Secondary Number or Email:
Responsible Party Name (Minors/Caregiver):	Relationship to Minor:	Phone Number:
EMERGENCY Contact Name:	Phone Number(s):	Relationship:
Primary Care Physician:	Physician Phone Number:	

Consent to Treat

Informed consent means the potential risks, benefits and alternatives of physical therapy evaluation, treatment, and/or wellness services have been explained to you. The physical therapist provides a range of services and I understand I will receive information at the evaluation concerning possible treatment options available for my condition.

Potential Risks: I may experience an increase in my current pain level/discomfort or an aggravation of my existing injury/condition. The discomfort is usually temporary and if it does not subside within 24 hours, I agree to contact my physical therapist. I may not be cured of my condition.

Potential Benefits: I may see an improvement in my pain/discomfort and ability to perform daily activities. I may experience gains in strength, endurance, flexibility, range of motion, awareness, knowledge and self-management of my condition.

Alternatives: I may choose not to participate in physical therapy. I will discuss medical, surgical, pharmacological or other alternatives with my physician or primary care provider.

I consent to rehabilitation and related services at True North Physical Therapy, LLC via direct evaluation and treatment as advised by my physical therapist. In doing so, I understand and affirm rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

_____ (initial)

Treatment of Minors

I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand I have been advised to remain on the premises during any evaluation and treatment.

_____ (initial)

Attendance

At True North Physical Therapy, LLC, I am committed to the highest quality of care. Consistent care is what allows us to effectively and efficiently meet your goals. I understand things come up in life and at times you may need to cancel an appointment. If you need to cancel, please give me more than 24 hours notice. **Failure to give more than 24 hours notice may result in a $25 cancellation fee.** True North Physical Therapy, LLC reserves the right to refuse to treat patients who habitually cancel or fail to show up for scheduled appointments. **Your time is valuable- I make every effort to start your appointment on time.** Please arrive prior to the start of your appointment to begin on time. **If a patient arrives greater than 10 minutes late, I may need you to reschedule your appointment.**

_____ (initial)

Release of Medical Records

I give permission to True North Physical Therapy, LLC to release verbal and written information from my medical records to my physician, other related healthcare providers, case manager, school, attorney, and/or insurance company as it relates to my treatment. I also authorize True North Physical Therapy, LLC to obtain medical records from my physician or other health care providers as it relates to my treatment.

_____ (initial)

Communication of Health Information

I give permission to True North Physical Therapy, LLC to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ **I do not** wish to disclose any information related to my medical condition(s).

_____ (initial)

Privacy

I have read and fully understand True North Physical Therapy's Privacy Practices. A hard copy of the Privacy Practices is available and obtainable upon request. I understand I have certain rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this information can and will be used to: conduct, plan and direct my treatment, follow up among multiple healthcare providers who may be involved in the treatment directly and indirectly, obtain payment, evaluate quality of services and any other administrative operations related to treatment and payment. I understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand True North Physical Therapy, LLC 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 noted in True North Physical Therapy's Privacy Practices. I understand I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ (initial)

Electronic Information

I understand my physical therapist utilizes a secure, HIPAA compliant, online scheduling system called Acuity Scheduling**,** as well as email, cell phone (voicemail, texting) and doxy.me, a HIPPA compliant platform for telehealth in daily operations. I understand technology puts some of my personal information at risk. For example, a cell phone with my personal information may be misplaced or stolen. Although True North Physical Therapy, LLC uses password protected devices, information regarding my treatment may be transmitted electronically, carrying with it the inherent risk of being viewed by unintended audiences. **Any payment or credit card information will only be transmitted on a confidential secure banking platform-Square, Inc.**

_____ (initial)

Direct Pay Policy

True North Physical Therapy, LLC is a direct pay physical therapy practice. Direct pay allows the cost of physical therapy to be more reasonable than traditional health care clinics. When the patient is responsible for payment, it eliminates overhead costs related to staff verifying insurance, billing third party payers, and collecting delayed payments. It also allows all individuals to seek care at True North Physical Therapy, LLC regardless of insurance carrier, being under-insured, un-insured, in or out of network.

Payment for all service is due at the time of service. Payment may be rendered via cash, check, debit/credit card or HAS/FSA. True North Physical Therapy, LLC does not bill insurance for physical therapy services provided. **Please note you will be charged $35.00 for any checks with nonsufficient funds.**

Prior to your first appointment, you should contact your insurance company to completely understand your benefits. Some private insurance companies may cover part or all of your physical therapy services with True North Physical Therapy, LLC deemed an out-of-network provider. If you would like to submit your physical therapy services to your insurance carrier, I will provide you with a detailed receipt of services rendered. It is the patient's responsibility to submit the appropriate paperwork to their insurance carrier. The amount of reimbursement will vary according to the terms of your insurance policy. I cannot guarantee or estimate reimbursement. Wellness/prevention services are typically not covered.
"I have read and understand the Patient Agreement for Cash-Based Policy and agree to pay for services rendered, in full, at the time of service. I understand it is my responsibility to work with my health insurance, HSA, or FSA to try to obtain any reimbursement I may be eligible for."

_____ (initial)

I AGREE TO ALL OF THE ABOVE NOTED POLICIES OF TRUE NORTH PHYSICAL THERAPY, LLC.

Do not sign unless you have read and thoroughly understand this form.

_____ _____

Patient Signature Date

_____ _____

Parent / Guardian Signature (if patient under 18 years of age) Date

_____ _____

Physical Therapist Signature Date