the manual touch
PHYSICAL THERAPY

THE MANUAL TOUCH POLICIES

CONSENT TO EVALUATE/TREAT

I, for myself, or the patient named above, hereby consent to such medical evaluation (e.g. impairment rating, IME) and/or treatment and diagnostic procedures (e.g. videotaping) as necessary and appropriate for my condition or illness based on the judgment of my healthcare provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my healthcare provider, ask questions regarding such treatment options and understand the options discussed.

NOTICE OF PRIVACY PRACTICES AND CONTACT AUTHORIZATION

The **Notice of Privacy Practice (NPP**) tells you how we may use and share your health records. It also describes your rights with respect to your health records. **Please read it. The NPP is available at The Manual Touch front desk.**

- We will use and share your health records to treat you and to bill you for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required/allowed by law.

Please complete below if appropriate: **I give authorization to the staff of The Manual Touch to discuss my medical information with the following people not listed in current medical records:**

Name **Name**

CONTACT AUTHORIZATION (Please CHECK the appropriate answer below)

Do the therapists and staff of The Manual Touch and Quality Time Billing (QTB) have your permission to leave messages containing medical and/or financial information on your voice mail?

At home _________YES __________ NO

At work _________YES __________ NO

On cell _________ YES __________ NO

**If you check "NO", the date, time, and location of appointments will be left on your voice mail.*

Do the therapists and staff of The Manual Touch have your permission to communicate via text about non-medical information ONLY on your cell? **______YES ______NO**

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ACKNOWLEDGEMENT OF RECEIPT OF THE MANUAL TOUCH FINANCIAL POLICY

We are committed to the successful treatment of your medical condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at **815-513-3654**.

The patient, or legal guardian, is always responsible for payment. In consideration of services to be rendered, you, as the undersigned patient or guarantor for patient, agree to pay The Manual Touch for all services and supplies provided to you (or the patient, as applicable) at the established rates, including any deductibles, co-payment or other charges, as permitted by third party payers. By signing this financial policy summary, you accept responsibility for any costs, including attorney's fees incurred by The Manual Touch in the collection of these charges for examination, diagnosis and treatment received. Furthermore, you certify that the information given by you for purposes of payment is, to the best of your knowledge, complete and accurate.

Additionally:

➢ Full payment is due at the time of service for self-pay patients or if insurance information (and copy of insurance card) has **NOT** been provided.

➢ If this is an insurance claim, after the insurance has completed processing your claim, you will have **30 days to pay the balance of the charge or make arrangements with our billing department, Quality Time Billing (QTB).**

➢ All patients must complete our "patient registration form" and other forms provided at the time of registration.

➢ If you would like us to bill your insurance directly, we **MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD** otherwise you will be billed.

➢ Please notify us immediately of any changes in your insurance information or coverage.

➢ At least 24 hours' notice is required for copies of medical records and there may be a nominal fee.

➢ If you're here for a workers' compensation or accident claim, we will need your health insurance information and will bill that insurance if we do not receive proper documentation and/or payment from the workers compensation or accident insurance carrier.

➢ You are ultimately responsible for payment of all services.

Insurance Disputes: If there is a dispute regarding the payment of your insurance or certain workers' compensation claim, The Manual Touch has the right to bill you prior to the resolution of that dispute and to anticipate payment from you.

Please initial each statement below:

___I understand that it is my responsibility to inform The Manual Touch of any desired changes in these authorizations. I assume full responsibility for all items of personal property that I have brought to The Manual Touch and release The Manual Touch of all liability in the event of loss or damage to such property.

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___I understand that the Notice of Privacy Practices (NPP) is available at my physical therapist's office. I acknowledge receipt of The Manual Touch NPP.

___I have received a copy of the HIPAA Privacy Policy for The Manual Touch Physical Therapy.

___I understand that the office agrees to bill insurance carrier as a courtesy to me. I must submit information as needed by my insurance company or to The Manual Touch to guarantee payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

___The Manual Touch and Quality Time Billing email is encrypted and fully HIPPA compliant however, there may be some level of risk that this information could be read by an unauthorized party. By providing my e-mail address, I am accepting the risks and authorizing The Manual Touch, its physical therapists and staff to communicate with me electronically about my care, account, The Manual Touch service surveys, products and services, and/or education.

___The Manual Touch reserves the right to modify the privacy policy outlined in the notice.

___I, for myself, or the patient named below, hereby consent to such medical evaluation(s) and/or treatment and diagnostic procedures as necessary and appropriate for my condition based on the judgment of my health care provider(s).

___ I, for myself, or the patient named below, hereby consent to video or photography as needed for medical purposes.

Note: This authorization expires one year after the date of signature.

Patient Name

Signature of Patient/Guardian/Representative **Date**

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CANCELLATION/NO SHOW POLICY

The goals at The Manual Touch Physical Therapy is to provide you with high quality, one on one care, to get you better as fast as possible and meet your goals. Attending all your appointments, as recommended by your physical therapist, as well as being on time, will help you achieve your goals. **However, we do understand that at times emergencies and conflicts with your appointment times will arise.**

We ask that you contact our office at least 24 hours in advance of your appointment to cancel and reschedule your appointment. When you call to cancel with less than **24** hours notice or miss your appointment without calling at all, classified as a “No Show”, your therapist does not have the opportunity to offer that time to someone else in need of services.

The charge for a cancellation with less than 24 hour notice or a no show is $50.

INSURANCE DOES NOT COVER THIS FEE

- Fees for missed or cancelled appointments must be paid before the patients next scheduled appointment.
- When a patient is late for their appointment time, the patient incurs the loss of time, and payment for the full session is expected.
- When a patient “No Shows” for 3 appointments without calling, the patient will be removed from the schedule.

Any special circumstances will be submitted to our Practice Manager for review.

Cancellation of an Appointment

You may cancel your scheduled appointment by calling either of the following numbers 24 hours prior to your appointment time. If no one is available to answer, there is a voice messaging system that is checked hourly during regular business hours.

(815)513-3654 **(847)541-7600**

I authorize The Manual Touch and understand that I will be billed for the applicable fee. I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointment.

____ ____________________

Patient or Guardian signature **Date**