CONSENT TO TREATMENT

I am a patient/guardian of a patient at Xzact Therapy & Aquatics. My signature certifies that I have been informed of my rights and duties as a patient and that I have had opportunity to ask any questions I may have about those topics.

I understand that all information regarding diagnosis and treatment is confidential and will not be released to any entity or individual without my written consent unless required by law. I understand that some issues, such as child abuse or danger to the life or safety of a third party, may require Xzact Therapy & Aquatics to release information about my diagnosis and treatment. I have been provided with written information about my medical records, HIPAA law protections and the care to be provided by Xzact Therapy & Aquatics and have had opportunity to review those documents.

I have been informed that certain information regarding treatment and test results will not be given over the phone and that I must make an appointment with my provider to receive such information.

I have been told that certain services, including some laboratory tests, may not be paid for by my insurer and that I will be asked to sign an Advance Beneficiary Notice with regard to those services.

I have given my consent to **Xzact Therapy & Aquatics** its agents and employees to provide me with the treatment contained in my medical chart and records. I understand that I am responsible for paying for this treatment if my insurer does not cover that treatment.

I hereby designate the following individuals as authorized to access my medical records or to receive information from my provider:

I understand that email may not be a secure medium for transmittal of information. I authorize my provider to release test results or information to me via the following, where applicable:

___ phone number in my records ______cell phone _____email _______USPS

ASSIGNMENT OF BENEFIT:

I hereby assign all necessary medical/ physical therapy benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers, including Medicare, Medicaid, MCOs, private insurance and any other health or medical benefit plan to issue all payment directly to **Xzact Therapy & Aquatics** for medical services rendered to me or my dependents. Overage payments are to be credited to me in accordance with law. I understand that I am responsible for any amount not covered by insurance.

____

Patient Signature Date

____

Personal Representative Signature (if applicable) Relationship to Patient

I also have read and understand that the Cancellation and No Show policy on the initial page of this packet is in effect and I agree to comply with such.

____

Patient or Responsible Party Signature Date

Commitment to Physical Therapy

Late, No-Show, Cancellation and Re-Scheduling Policies

Your adherence to the recommended number of treatments is a vital component of your progress with our services. While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last-minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. The following policies are in place to motivate commitment.

- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, or a fee will be charged for that appointment. ($50 for evaluation/$25 for following visits)

- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments and your referring doctor will be notified concerning your non-compliance.

- If you are more than 15 minutes late for your appointment and fail to notify us, we hold the right to consider your appointment a "No-Show". As per the no-show policy a fee will be applied.

- No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled. However, Friday appointments will be charged due to no opportunity to reschedule for the same week.

- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.

- ALL PATIENTS, regardless of insurance/third party payor, will be charged a CANCELLATION FEE ($50 evaluation/$25 following visits) for each late, late cancelled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.

- Repeated failure to not comply with this COMMITMENT TO THERAPY POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

****The cancellation fee will be due before your next visit. If you refuse to pay, we reserve the right to turn your care back to your referring physician.**

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Thank you for providing our office and our patients with this courtesy.

I have read, understand, and agree to abide by the policy above:

Print name: ____

______________________________ ____________

Signature of Patient (or Responsible Party) **Date**

HAVE YOU HAD ANY THERAPY AT ANY OTHER FACILITY THIS YEAR? THIS INCLUDES CHIROPRACTIC, SPEECH THERAPY, OCCUPATIONAL THERAPY, OR PHYSICAL THERAPY? ______YES ______NO IF YES, PLEASE SPECIFY.

____

CHIEF COMPLAINT:

What are we treating you for?____

What is the Onset Date (your initial symptom or pain) for this illness/injury?______________

Have you had surgery for this?______________When?__________

Have you had prior therapy for this?___________When?__________

Was this an accident related injury?___________If yes, when was the accident?______________

Is this a work related accident?________

IS THIS A WORK COMP CLAIM?_________ ADJUSTER NAME:______________PHONE__________

IS THIS A LAW SUIT CLAIM?______________NAME OF LAW FIRM:____________________

Have you been on home health within the past 60 days?________

Are you currently being seen by a Home Health Agency?________

If yes, PLEASE ANSWER FOLLOWING QUESTIONS!!!!

Which home health agency?________________________

DOES A NURSE COME TO SEE YOU?________

DOES SOMEONE JUST COME TO CLEAN AND HELP YOU DO THINGS AT HOME?__________

Do you have a pacemaker or defibrillator? Yes No
Are you pregnant? Yes No

***Primary* Physician:**____

Address:____

City:__________________________**State:**____________________**Zip Code:**________

Phone Number:____

f you would like to have an **APPOINTMENT REMINDER**, please fill out section below:

ircle one: **CELL PHONE or EMAIL** If Cell phone, ***WE WILL NEED TO KNOW YOUR PHONE CARRIER IN ORDER TO SEND YOU A EXT?***

LEASE CIRCLE YOUR CARRIER!

LLTEL AT&T BOOST MOBILE CRICKET VERIZO METRO PCS SPRINT PCS T-MOBILE US CELLULAR
THER:____________

XZACT
THERAPY + AQUATICS

LIST OF MEDICATIONS PATIENT CURRENTLY TAKES

______________________________ DOSAGE __________

______________________________ DOSAGE __________

______________________________ DOSAGE __________

______________________________ DOSAGE __________

______________________________ DOSAGE __________

______________________________ DOSAGE __________

______________________________ DOSAGE __________

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