CONSENT TO TREAT

INTRODUCTION:
The purpose of physical therapy is to rehabilitate individuals following injury, surgery or disease with the goal of achieving maximal patient potential and accelerate recovery. Treatment is patient specific, and will include careful evaluation followed by intervention. Intervention may include, but is not limited to manual techniques, functional stretching, strengthening, home exercise prescription as well as the use of modalities.

POTENTIAL BENEFITS:
I understand that my physical therapist cannot make any promises nor guarantees regarding a cure for, or improvements in my condition. My physical therapist will educate me on potential results of treatment for my condition and will discuss treatment options with me before I consent to care. Usual benefits may include a decrease in my symptoms and an increase in my ability to perform my daily activities. I may experience strength and flexibility gain, heightened endurance and improved body awareness. I should gain a greater knowledge about managing my condition and the resources available to me.

POTENTIAL RISKS:
As with any health care procedure complications may arise during the course of treatment. Adverse effects may include but are not limited to possible increase in my current level of pain discomfort, or aggravation with an existing injury. This discomfort is usually temporary, but if it persists or if I do not tolerate any part of my prescribed interventions I agree to inform my physical therapist. I am aware that every precaution is taken to deliver modalities safely, there is a small risk of skin irritation or burning with the use of electrical modalities, ice, heat or tape.

I acknowledge I have discussed the potential risks and benefits of physical therapy with my referring provider. _____ (Initials)

COMMUNICATION:
It is my responsibility to notify my physical therapist of any known physical conditions, including pregnancy, the intent to become pregnant, and any changes to my health or medication(s). I will also notify a member of the physical therapy team if I experience any discomfort during therapy so that treatment can be adjusted.

INFORMED CONSENT FOR TREATMENT:
The term “Informed Consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. I understand all procedures will be thoroughly explained to me before they are performed and any questions will be addressed to my satisfaction. Having been informed of the risks, I hereby give my consent to treatment. I understand that I am able to decline any part of my therapy program at any time. If pregnant or trying to conceive, I authorize my practitioner to administer treatment during my pregnancy. I allow this consent form to cover the entire course of treatment for my present condition and for future conditions(s) for which I seek treatment. By consenting below, I acknowledge that I have weighed the risks involved in undergoing treatment and have determined it is in my best interest to proceed with the treatment recommended. This consent will be in effect for 1 year from the date of endorsement.

I have read the above consent for Quinn Orthopedic Physical Therapy. My signature below acknowledges that I have understood and will abide by the conditions and policies noted on this consent form.

Patient Name/Responsible Party: _____ Date: _____

Parent/Guardian (if applicable): _____

Signature: _____

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

As part of my health care, **Quinn Orthopedic Physical Therapy** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among the company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for the company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that the company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that the company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

My signature below acknowledges that I have received a copy of the Notice of Privacy Practices of Quinn and agree to the liability limitations explained therein.

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Patient Name: _____ Date: _____

Parent/Guardian (if applicable): _____

Signature: _____

Revised December 20, 2023

AGREEMENT OF FINANCIAL RESPONSIBILITY

INTRODUCTION:
Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and sign prior to initiation of treatment. Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records.

Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit card, and pre-approved insurance for which we are a contracted provider.

INSURANCE:
The patient is ultimately responsible for any charges rendered on their account. As a courtesy, Quinn Physical Therapy will bill the indicated insurance company on your behalf. It is your responsibility to know your own insurance benefits including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

It is your responsibility to provide current and accurate insurance information, including updates or changes in coverage. Failure to provide this information will result in patient fiscal responsibility. After 60 days, any balance not paid by the insurance will become your liability.

You may elect to pay out of pocket for physical therapy services. For patients without insurance or for those who elect to pay out of pocket, a discounted “cash rate” of $200 for the initial evaluation and $100 for follow-up appointments will apply. If we do not contract with your insurance company, payment will be due at the time of service. We will provide you with a statement that you can submit to your insurance company for reimbursement.

CO-PAYMENT:
You are responsible for paying any deductible due at the time of service. If your outstanding balance with our team exceeds $300, you will be ineligible for continued service until reasonable effort towards payment has been made. With financial hardship, please seek collaboration with our billing manager for possible situational accommodations.

CANCELATION & NO SHOW POLICY:
In the event that you need to cancel a scheduled appointment, you agree to provide a courtesy of 24-hours notice by phone (408-252-6076) or email (info@quinnpt.com) as such that Quinn can offer my appointment to patients waiting on the standby list. If you cannot attend my appointment due to an unforeseen illness, a minimum of 4-hours notice prior to the scheduled appointment is expected. With failure to notify, as outlined above, the appointment will be documented as a no-show. All patients agree upon intake to the No Show Policy that allows for a $50 penalty fee for each occurrence of a No Show.

In practice, we are not in the business of charging patients for appointments they did not attend. Our objective is to minimize the occurrence of No Shows. We want our patients to derive value from their visits and to keep them as scheduled. Our No Show Policy is intended to provide corrective incentive to our patients to attend scheduled appointments, and to recoup a portion of our costs when patients do not give us the courtesy of notice, and the opportunity to fill their canceled appointment with a patient from the stand-by list.

My signature below acknowledges that I have understood and will abide by the conditions and policies noted on this consent form.

Patient Name: _____ Date: _____

Parent/Guardian (if applicable): _____

Signature: _____