Mountain Land. PHYSICAL THERAPY & REHABILITATION

Consent and Conditions of Service Form

Patient Name (Last, First, MI)	Date of Birth (MM/DD/YYYY)	(Office Use Only) Witness Initial:

Welcome to Mountain Land Rehabilitation (MLR). Thank you for choosing MLR to be your therapy provider. Our therapists are licensed and trained to use evaluation and treatment techniques to help restore you to your optimal activity level. As with all medical care, we are obligated to inform you that there are potential risks associated with treatment. Since the physical response to therapy can vary widely from person to person, it is not always possible to predict your response to certain exercises or procedures. It is possible that therapy may cause pain, injury, or may aggravate previously existing conditions. We encourage you to communicate openly with your therapist during the evaluation and treatment process. You have the right to decline any portion of your treatment at any time before or during a treatment session.

Release of Information and HIPAA/Privacy Acknowledgment: MLR is required by law (Office of Civil Rights) to protect the privacy of your medical records. MLR uses and discloses medical records ONLY in accordance with state and federal privacy laws (HIPAA). Uses and disclosures are described in the MLR Notice of Privacy Practice. You may request a copy of this document at any time.
I acknowledge that I have been offered a copy of the MLR Notice of Privacy Practice. **Initial _____**

Patient Medical Record Authorization:
I authorize MLR to provide my confidential health information to the following individual(s).
Name_____ Relationship to Patient _____
Name _____ Relationship to Patient _____

Appointment Reminders:
I authorize MLR to send me appointment reminders via text message or email. **Initial _____**

I understand and agree that a $25.00 fee will be assessed if I do not provide a cancellation notice before the end of the business day prior to a scheduled appointment. Assessed fees must be paid prior to receiving the next treatment. **Initial _____**

Financial Responsibility:
I (Patient or Authorized Representative) agree to pay for any amounts not paid by an insurance company or other third party payer (excluding contract discounts) for care provided. I understand that I am responsible for all co-payments, deductibles, co-insurance, and/or non-covered services. I also agree to pay a Same-Day Rate OR published Piece Rates for care provided when or if I choose to not have my insurance billed.
Initial _____

Unresolved Account Balances: I understand that interest does not accrue and statements are not mailed to me until after my insurance(s) has paid and I am left with a balance. I understand and agree that any remaining balance on my account not paid within 30 days of the statement date, accrues interest at the rate of 1.5% per month (18% per year). I understand that my balance will be sent to a collection agency if I choose not to pay for care provided. In the event an unpaid balance is placed with a collection agency or attorney, I agree to pay the unpaid balance (including interest), and a collection fee up to 40%, in addition to all related attorney fees.
Initial _____

For Medicare/Medicaid/Tricare/Veterans Administration Patient's Certification ONLY: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act, or in connection with any other government program, is correct. I authorize MLR to release documentation regarding my therapy services to the Social Security Administration, fiscal intermediary, insurance payer, or state agency in order to process a claim for my therapy services. **Initial _____**

Assignment of Benefits:
I request and authorize my health insurance carrier to pay MLR directly for all charges related to services provided to me by MLR or other providers who have authorized MLR to bill on their behalf. **Initial _____**

My initials above, and signature below, acknowledge that I have read, understand, and agree to the terms of this authorization form and give my consent to proceed with a therapy evaluation and corresponding treatment.

I understand that I am entitled to request and obtain a copy of this document. This document will remain in effect unless revoked in writing by the Patient or Authorized Representative.

Signature:	Date:
Printed Name:	Social Security Number (Patient or Signee):
If Signee is someone other than the patient please fill out the below information:	
Relationship to Patient:	Date of Birth of Signee: