AUTHORIZATION & ACKNOWLEDGEMENTS

TREATMENT AUTHORIZATION: I Authorize for treatment of myself or my minor child by the therapists and staff at Kinetic Physical Therapy and Wellness.

INFORMED CONSENT: The term "informed consent" means that the potential risks, benefits, and alternatives of physical, occupational, or speech therapy treatment have been explained to me.

The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Therapy services involve the use of many different types of physical evaluation and treatment. At Kinetic, we use a variety of procedures and modalities to help us to try to improve your level of function. As with all forms of medical treatment, there are benefits and risks involved with physical, occupational, and speech therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality of procedures. We are not able to guarantee precisely what your reaction to a particular treatment might be. There is also a risk that some treatments may cause pain or injury or may aggravate previously existing conditions. You have the right to ask your therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them. If I do not wish to participate in the therapy and/or exercise program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

REFERRAL AUTHORIZATION: Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy, although we are glad to assist. If your insurance carrier required an authorization for service no service will be rendered until authorization is obtained. Furthermore, we may be required to contact your physician for a treatment order referral for services.

SECURITY AND VIDEO: Kinetic uses closed circuit video for security coverage in some of our common areas. This video footage is not used for marketing or advertising purposes but only for the sole use of and safety and security review by the staff of Kinetic or by local security and safety officials.

CANCELLATION AND/OR NO-SHOW POLICY: Kinetic urges you to keep every appointment, as consistent treatment will expedite your recovery. **In the event you need to cancel an appointment, we request at least 24 hours' notice**, excluding Saturday and Sunday. **If the patient is 15 minutes past their scheduled time we may have to reschedule your appointment and consider it a cancellation**. Because we schedule your therapist based on your scheduled time, **after 3 consecutive cancellations or 2 consecutive no-shows, we will discharge you from services** so that we can offer therapy services to those who are awaiting access to care.

Patient/Guardian Initials Here ____________

ASSIGNMENT OF BENEFITS: I authorize payment of my Medicare and/or Insurance benefits to be made directly to Kinetic on my behalf for services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payment are made directly to me, I will endorse such payments to Kinetic Physical Therapy and Wellness within five (5) days of receipt of such payment.

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL Kinetic Physical Therapy and Wellness SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, Kinetic Physical Therapy and Wellness will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Kinetic Physical Therapy and Wellness to take action to secure payment of an outstanding balance owed. Patients who are attending under a workers compensation claim hold no financial responsibility for services rendered.

FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE: Kinetic Physical Therapy and Wellness is a participating provider of Medicare; as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office you are responsible to pay your deductible to Kinetic Physical Therapy and Wellness. After your deductible is satisfied, Medicare will reimburse us 80% of their standard fee for Therapy services. Therefore your payment responsibility is 20% of the standard Medicare fee for Therapy services.

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form, I acknowledge that I have discussed, or have the opportunity to discuss, with my therapist the nature and purpose of Therapy treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorization. I consent to the Therapy treatments offered or recommended to me by my Therapist. I intend this consent to apply to all my present and future Therapy care.

____________________________________ ________________________

Patient's Signature (or Parent or Guardian if under 18) Date

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Patient's Printed Name

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(Parent or Guardian Printed Name if under 18)