Inspire Physical Therapy
and *Wellness*
Allison Ariail, Doctor of Physical Therapy
www.inspireptwellness.com
Phone: 303.944.6684 Fax: 720.389.8277

CONDITIONS & CONSENT FOR PHYSICAL THERAPY TREATMENT

I understand that I am a patient of Allison Ariail who is an independent Physical Therapy practitioner at Inspire Physical Therapy and Wellness. My care is the exclusive responsibility of Allison Ariail, DPT not of any other practitioners who also may practice at this location.

Cooperation with treatment:
In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. 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.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to let my physical therapist know.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Financial and insurance responsibilities:
I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt that is my responsibility to submit to my insurance company.

☐ **I have read the above information and I consent to physical therapy evaluation and treatment.**

_____ _____
Print Name Date

_____ _____
Patient or guardian signature Therapist signature / Date

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Cancellation and Financial Policies

At Inspire Physical Therapy and Wellness, we are committed to providing you with the best possible physical therapy care. Attending scheduled visits and the timely payment of your bill are essential parts of your treatment. Please read and sign that you understand the financial and cancellation policies below.

I understand that attending scheduled visits is essential in making progress towards my therapy goals. I agree to attend scheduled visits and call at least 24 hours in advance if I need to cancel. I am allowed one same day cancellation in a 3-month period for illness and weather related issues. If I need to cancel 3 or more visits in this same time frame, I may be removed from the schedule until I am able to attend visits more regularly.

_____ _____
Signature of Patient or Responsible Party Date

I understand that all payment is due prior to service.
Our rates are as follow:
□ Initial Appointment and treatment: $150
□ Follow up one-hour treatment: $105
□ Payment is due the same day of service.

Additional Fees:
□ A fee of $25.00 will be charged for any returned check
□ A fee of $30.00 for a second no-show or same day (less than 24 hour) cancellation within a 3-month period since the first no-show. Patients are given a reminder email, call, or text prior to appointments. Please inform your therapist if you have not received a reminder.
□ Any equipment that is purchased will be paid for upfront (probes, home exercise tools, etc).

_____ _____
Signature of Patient or Responsible Party Date

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Electronic communications statement and policy:

By choosing to use the convenience of e-mail to communicate with me, you understand and agree to the following:

- The use of e-mail or text may pose risks to the confidentiality of your health information.
- The Internet and phone systems are an open network and provides no inherent protection for confidential information.
- You accept these risks.
- There will be times when I will not have access to e-mail. Be sure to contact my office by telephone when necessary
- **Please DO NOT use email or text to convey private health information. Rather, please use email for scheduling only**.

We will now have the capacity to send out group emails to inform patients when an appointment has opened up on the schedule or for when we are starting to schedule for a new month. All emails will be sent in BCC format, so recipients should not be able to see emails of the other patients. However, mistakes can occur, and electronic privacy is **NOT** guaranteed.

Please check all that apply:

_____Please do NOT include me on group emails

_____Please include me on emails for when a new block of time is opening on the schedule (example: scheduling for summer is open). I understand that I can ask to be removed from this list at any time.

_____Please include me on emails when a cancellation on the schedule opens up. I understand I will receive two emails in these instances: one for when the appointment opens and a second email that tells if the appointment is filled. I understand that I can ask to be removed from this list at any time.

_____ Please send me text reminders for appointments at this phone number_____

_____ I do not do text messages. Please email me at _____

Thank you for helping us understand how to better serve you.

Sincerely,

Allison Ariail,

I, _____ (written name) have read and agree to the communication as specified above, understanding any/all privacy risk that may be involved. I also understand not to send any personal health information via electronic communication or via text.

_____ Patient signature _____ Date

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HIPPA NOTICE OF PRIVACY

Notice Of Privacy Practices For Protected Health Information
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This office is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this notice.
If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health: information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.
Examples of uses of your health information for treatment purposes are:
• A provider or assistant obtains treatment information about you and records it in a health record.
• During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will obtain your signed authorization before sharing information with such specialists to obtain his/her input.
• Referral information may be forwarded to Diagnostic Testing Labs for further treatment or testing where the provider will want results of such treatment or testing reported bock to him/her.
• If the provider is a specialist, your health information and progress may be reported back to your primary care provider or referring provider, upon receipt of your written authorization.
Example of use of your health information for payment purposes:
We submit requests for payment to your health insurance company. The health insurance company requests health information from us regarding medical care given. We will provide information to them about you and the care given. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.
Example of use of your health information for health care operations:
We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.
YOUR HEALTH INFORMATION RIGHTS
The health and billing records we maintain are the physical property of the treating provider. The information in it, however, belongs to you. You have the right to:
• Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted as required by law:
• Obtain a paper copy of the Notice of Privacy Practices for Protected Health information ("Notice") by making a request at our office.
• Request that you be allowed to inspect and copy your billing record - you may exercise this right by delivering the request in writing to our office;
• Obtain an accounting of disclosures of your health information as required to be maintained by law, upon request. An accounting will not include internal uses of information for treatment, payment, operations, or disclosures made to you; and
• Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.
You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

OUR RESPONSIBILITIES

This office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or our notice.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may file a claim with the Secretary of the department of health and human services at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. Likewise, we cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

OTHER DISCLOSURES AND USES

Notification of Family/Friends: Our office does NOT disclose protected health information or any other information to family members.

Appointment Reminders and Treatment Information: We may contact you and/or leave a message on your telephone answering machine to provide you with appointment reminders, prescription information, or billing information.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers Compensation. Additionally, we will report attendance adherence or non-compliance.

Abuse, Neglect & Domestic Violence: We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and safety or the health and safety of other individuals.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime in emergencies; and other appropriate situations as permitted by law.

Judicial/Administrative Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, discovery request or other lawful process if certain specific requirements are met. To avert a serious threat to health or safely, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Other Uses: Any other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

☐ I HAVE BEEN OFFERED AND ***RECEIVED*** A COPY OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

☐ I HAVE BEEN OFFERED AND ***DECLINED*** A COPY OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Signature_____ Date _____