VERMONT PHYSICAL THERAPY

MEDICALLY INFORMED CONSENT

CONSENT TO TREAT

To the patient: you have the right to be informed about your condition and the recommended physical, medical and/or diagnostic procedure to be used so that you may make an informed decision on whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

In order to provide any sort of medical care to you, you as the patient must willingly consent to said care and any evaluation done prior to beginning your care.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that:

> You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment is recommended; and you consent to treatment at this office or any other satellite office under common ownership; and this consent will remain fully effective until it is revoked in writing.

You have the right to discuss your treatment plan with your healthcare provider. Any concerns regarding testing or treatment should be discussed with your healthcare provider.

By signing below, you acknowledge and certify:
I voluntarily request a Physical Therapist, or the designees deemed as necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this medical practice.

I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____
(parent/guardian signature if patient is under 18 years old)

Parent/Guardian Name (Printed): _____ Date: _____

(If patient is under 18 years old)

VERMONT PHYSICAL THERAPY

ASSIGNMENT, RELEASE AND HIPAA

I hereby authorize my insurance benefits be paid directly to Vermont Physical Therapy and understand that I am financially responsible for non-covered services. I understand that if Vermont Physical Therapy does not contract with my insurance company, I am responsible for the fee for service charges. I also authorize the physician and/or Vermont Physical Therapy to release any information necessary to process this claim. All the information provided below is correct and true to the best of my knowledge.

- We will check your insurance coverage as a courtesy prior to or at your first visit. However, patients are responsible for understanding their own coverage and should be prepared to cover any costs associated with their care. VTPT does not guarantee the accuracy of information provided to us by your insurance company.
- Copays and self-pay patients are required to pay at time of service. We will bill patients with deductibles monthly.
- Patients who fail to satisfy their financial obligations to VTPT will be sent to collections and will be responsible for collection fees & associated costs.

VTPT is required by law under the Privacy Regulations as stated in the Health Insurance Portability Act (HIPAA) to protect any personal or health-related information we collect from you. If you wish to review our full Notice of Privacy Policy for Protected Health Information policy, please ask for a copy from the Front Desk

Your initials and signature below indicate you agree with the Assignment and Release policy.

_____ I understand that I have a copay of_____ which is due on date of service.

OR

_____I understand that I am paying $40 per visit on date of service towards my deductible/coinsurance balance. This payment will be applied to my account. I understand that I will receive a monthly statement with remaining patient responsibility as processed by my insurance.

I would like to speak to the Practice Manager about the cost of physical therapy services based on my insurance.

_____ Yes _____ No Insurance: _____

Payment Options

Please mark how you plan to pay for the patient responsibility charges as processed by your insurance.

_____ I will provide payment with check. (* Please note - A credit card on file is still required.)
_____ I will provide payment with credit card.
_____ I will provide payment using an HSA account.
_____ I will provide payment through my employer.

Employer payment program name: _____

Employer: _____

CANCELLATION POLICY

I understand and agree with Vermont Physical Therapy's NO SHOW/CANCELLATION/ RESCHEDULING policy: **I will be charged a $75.00 fee in the event that I miss an appointment, cancel and / or reschedule in less than a 24-hour (1 business day) period**.
Vermont Physical Therapy does require a health savings account card or credit card to be kept on file to ensure copayment on date of service, coinsurance fees and remaining account balances that fall to patient responsibility. **Missed Appointment Fees ($75) will automatically be charged to the card provided.**

HSA/Credit Card Information

_____
Card Number Expiration Date

_____
Name on Card

_____I understand that upon receipt of my statement, I am required to pay the balance within 15 days of the statement date.

_____ _____

Signature

VERMONT PHYSICAL THERAPY

PATIENT DEMOGRAPHIC INFORMATION

Please complete this demographics form as a confirmation that the information we gather over the phone is accurate.

Patient Information	
Last Name:	Phone #:
First Name:	Street Address:
Date of Birth:	Suite/Apt.:
Gender at birth*:	City:
Pronouns:	State:
Email:	Zip Code:

Guardian Information (if patient is under 18 years old)	
Last Name:	Street Address:
First Name:	Suite/Apt.:
Pronouns:	City:
Phone #:	State:
Email:	Zip Code:

General Medical Information	
Primary Care Provider Name:	Primary Care Provider Phone #:
Emergency Contact Name:	Emergency Contact Phone #:
Referring Provider Name (if different than PCP):	Referring Provider Phone # (if different than PCP):

How did you hear about us? _____

Patient Signature: _____ Date: _____
(parent/guardian signature if patient is under 18 years old)

**This information is gathered for insurance purposes only; we will honor your pronouns as indicated on this form.*

VERMONT PHYSICAL THERAPY

MEDICAL HISTORY

Do you or have you experienced any of the following?

Alzheimer's	Y	N	Other reproductive issues	Y	N
Cardiovascular Disease	Y	N	Currently Pregnant	Y	N
Cerebral Vascular Accident	Y	N	Complicated Pregnancies	Y	N
Current Infection	Y	N	Alcoholism	Y	N
Diabetes Type 1 OR II	Y	N	Blood Disorders	Y	N
Fibromyalgia	Y	N	Chest Pain/Shortness of Breath	Y	N
Fracture/Suspected Fracture	Y	N	HIV +	Y	N
High Blood Pressure	Y	N	Thyroid Condition	Y	N
Hx of Cancer	Y	N	Urinary/bowel Incontinence	Y	N
Immunosuppressed	Y	N	Impaired Hearing	Y	N
Muscular Dystrophy	Y	N	Impaired, uncorrected vision	Y	N
Osteoarthritis	Y	N	Joint Pain/Swelling	Y	N
Parkinson's	Y	N	Lung Disease	Y	N
Rheumatoid Arthritis	Y	N	Neurological Disorder	Y	N
Traumatic Brain Injury	Y	N	Recent weight loss/gain	Y	N
Abnormal Menstrual Cycles	Y	N	Psychological Disorders	Y	N
Pelvic Inflammatory Disease	Y	N			

Height: _____ft _____in, Weight: _____lbs Other: _____ Y N

Please list all medications you are currently taking or provide us with a separate med list:

Medication	**Dosage/Frequency**	**Reason**

Any known allergies/sensitivities? _____

Please list all surgeries with approximate dates:

_____

_____

Please list any diagnostic testing done for this current injury or condition:

_____

Patient Name (Printed): _____

Patient Signature: _____ Date: _____
(parent/guardian signature if patient is under 18 years old)

Parent/Guardian Name (Printed): _____Date: _____
(If patient is under 18 years old)