Triumph Physical Therapy

8350 Richardson Rd.
Commerce Township, MI. 48382
Phone 947-800-7117
Fax 947-800-7109

Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s) health care provider(s). I acknowledge that no guarantees have been make to me about the results of treatment.
2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $30 or $60 depending on appointment type.
   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled we are required to inform you Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or cancelled appointments. It is also required that all missed visits be rescheduled.
3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Triumph Physical Therapy. I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Triumph Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balances will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.
   Please note that refusal to sign this form does not change responsibility for payment in any way.
4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Triumph Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.
5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that Triumph Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Triumph Physical Therapy's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Triumph Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.
6. **HIPAA CONSENTS:** In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

________________________	________________________	________________________
Name/Relationship	Name/Relationship	Name/Relationship

I also authorize the release for appointment information left in a voice mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

CONSENT FOR EMERGENCY CONTACT INFORMATION

Person to contact in case of an emergency:

____ ____________________

Signature of Patient or legally Responsible Person Date

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Printed Name of above