PELVIC THERAPY AND FITNESS LLC
2500 W. Higgins Road Suite 1100, Hoffman Estates, IL 60169
ptf@pelvictherapyfitness.com
847-989-1491

PATIENT CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

Consent for Treatment

I hereby consent to, and authorize my physical therapist, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin and soreness after treatment, including, without limitation, myofascial release and soft tissue mobilization. I understand that my treatment may include, with my consent, examination of the pelvic floor performed either vaginally or rectally. I understand that it is my responsibility to inform my physical therapist if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that each patient's response to physical therapy intervention varies from patient to patient and it is possible that treatment may result in aggravation of existing symptoms or may cause inflammation of the condition for which I am seeking treatment.

Initials: _____

I understand I may choose to have a chaperone from the clinic or bring my own during my pelvic floor treatments/examinations. I understand I can change my options at any time during the course of my treatments.

Initials: _____

Appointment Attendance Agreement

I understand the importance of attending therapy consistently, scheduling appointments in advance 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 and acknowledge that appointment times given one week may not be available in subsequent weeks. I agree to provide notice to you at least 24 hours before if I need to cancel an appointment and I understand that cancellation of, or failing to keep an appointment with less than 24 hours prior notice will result in a cancellation fee of $50.00. Cancellation fees cannot be billed to insurance and are my responsibility.

Initials: _____

I acknowledge that I understand the Appointment Attendance Agreement and will be by my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Initials: _____

Responsibility for Payment

All co-payments and self-pay services are due at the time of service. I acknowledge that in consideration of the services provided to me by Pelvic Therapy and Fitness. I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Pelvic Therapy and Fitness with my current insurance information and to familiarize

PELVIC THERAPY AND FITNESS LLC
2500 W. Higgins Road Suite 1100, Hoffman Estates, IL 60169
ptf@pelvictherapyfitness.com
847-989-1491

myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or health insurance benefits should be directed to my health insurance provider. I understand that my health insurance may pay for all or a portion of the services I receive from Pelvic Therapy and Fitness, but that I am responsible for any unpaid balance including, but not limited to, my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance. I understand that Pelvic Therapy and Fitness will bill my health insurance as a courtesy, but that I am responsible for any amounts not paid. Pelvic Therapy and Fitness is only contracted with BCBS and Medicare at this time. All other sessions must be pre-paid or paid at time of service. Pelvic Therapy and Fitness will accept cash, personal checks and credit cards.

Credit Card Authorization: For your convenience, we can now securely store your credit card(s) in our system. Your full credit card number will be encrypted and tokenized, and will never be viewable or accessible to any staff members. I authorize Pelvic Therapy and Fitness LLC to store my credit card information and bill the card on file for the services I receive at Pelvic Therapy and Fitness LLC. I understand Pelvic Therapy and Fitness LLC will only charge this card for the amounts authorized by me and upon request a receipt will be provided.

Initials: _____

Assignment of Benefits

I hereby assign to Pelvic Therapy and Fitness all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with and to provide such information as is needed to establish my eligibility for such benefits.

Initials: _____

Access to Release of Health Information

I understand that Pelvic Therapy and Fitness 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 permit Pelvic Therapy and Fitness to provide information to any third party payer, insurance company, or agent which may be responsible in whole or part for paying my bill. I also permit the release of information to companies hired by these third parties to monitor utilization of rehabilitation services. Upon request, we will provide a receipt that you may choose to submit to your insurance company or health spending account. I authorize my clinician(s) and Pelvic Therapy and Fitness administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment.

Initials: _____

I acknowledge that Pelvic Therapy and Fitness has made the HIPAA Notice of Privacy Practices available to me and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

Initials: _____

PELVIC THERAPY AND FITNESS LLC
2500 W. Higgins Road Suite 1100, Hoffman Estates, IL 60169
ptf@pelvictherapyfitness.com
847-989-1491

Patient Name: _____

Patient/ Guardian Signature: _____

Date: _____

Pelvic Therapy and Fitness complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender.

For Minors ONLY

A parent or legal guardian needs to sign the above informed consent. If you would like to leave during a session or anticipate someone else bringing the patient, please fill out the form below.

As a parent/legal guardian, I authorize and give my consent for Pelvic Therapy and Fitness to treat

_____ **(minor's name) while I am not present.**

Print Name: _____

Guardian Signature: _____

Date: _____

Relationship to Patient: _____