ALLIANT REHABILITATION & SPORTS THERAPY, PLLC
4504 LILAC LANE, SUITE 1, VICTORIA, TEXAS
361-572-0385

PHYSICAL THERAPY CONSENT FORM

PATIENT'S NAME: ___________________________________

1. **CONSENT:** I consent to physical therapy services at Alliant Rehabilitation & Sports Therapy, PLLC. I know if I have any questions about my care, I should ask the physical therapist about them. I know it is up to me to inform the physical therapist/staff about any health problems, allergies, or medications I am taking. __________

2. **RELEASE OF INFORMATION:** Alliant Rehabilitation & Sports Therapy, PLLC releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits. ________

3. **INSURANCE:** I authorize the staff at Alliant Rehabilitation & Sports Therapy, PLLC to review my insurance coverage with my insurance company**. I understand that my insurance benefits are only a quote of benefits, not a guarantee of payment. I understand that what I am quoted by Alliant and/or my insurance company may differ from what I may owe at the conclusion of physical therapy. I understand it is my responsibility as the patient to know my insurance coverage. I authorize payment of my insurance benefits to be made directly to Alliant Rehabilitation & Sports Therapy, PLLC. I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that it is unlawful for Alliant Rehabilitation & Sports Therapy, PLLC to waive co-pays, co-insurances and deductibles that are my responsibility. For any returned check there will be a $35.00 fee added to my responsibility that will be included in my bill. If I do not pay my bill in the specified timeframe, then my balance will be sent to a collection agency and a 35% fee will be added to the unpaid balance and will be my responsibility.** __________

4. **NO GUARANTEES:** I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist or supportive personnel. _________

5. **NOTICE OF PRIVACY PRACTICE:** I have read the Alliant Rehabilitation & Sports Therapy, PLLC statement of Privacy Practice Notice and I understand that a copy of the notice will be provided to me upon my request. __________

6. **HAVE YOU RECEIVED ANY PHYSICAL THERAPY SERVICES WITHIN THE LAST YEAR? ☐ Yes or ☐ No**

7. **ARE YOU CURRENTLY RECEIVING HOME HEATLH SERVICES? ☐ Yes or ☐ No**

   I understand that it will be my responsibility for any charges not covered by my insurance due to overlap of services while a patient at Alliant Rehabilitation & Sports Therapy, PLLC. _________

***An **OVERLAP** in services can reflect in a **DENIAL** of payment from your insurance company. If an overlap in services occurs, the payment of service becomes the patient's responsibility.*

I certify that any and all information provided by me in furtherance of my application for health care benefits are true. I have read the information on this form. It has been fully explained to me and all my questions about the form have been answered. I understand its contents.

____	____
Patient Signature/Date	**Patient's Representative Signature/Date**
____	____
Witness/Date	**Relationship to Patient**