Patient Consent Form

I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist.

The patient is responsible for charges incurred, regardless of insurance coverage. If Rosette Physical Therapy, P.C (RPT) has a contract with the patient's insurance carrier, RPT will file the claim for patient's services. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I understand that I am responsible for all balances due.

I understand, in some instances, all or some of the applicable physical therapy charges billed to my insurance company may not be covered under my insurance policy. I agree to be responsible for any portion of my bill not covered by insurance. I understand that it is my responsibility to understand my insurance benefits and comply with the requirements of the policy.

_____ Initial here that I have read, agree with, and understand the above statements.

Appointment Times and Scheduling

All appointments are expected to last 50-60 minutes in length. RPT will contact the patient or caregiver prior to, or the morning of the appointment to confirm appointment time. RPT respects patient's time and makes every effort to arrive on schedule. However, because an employee cannot anticipate what every person will need, or if medical emergencies arise, she will take whatever time is necessary to give every patient the best care that is needed. As RPT employees makes home visits, one cannot foresee challenges in parking, heavy traffic, or unforeseen road conditions. For this reason, therapists will give a window between thirty to sixty minutes before or after the appointment time of arrival. If therapist is running more than thirty minutes late then patient will be called and notified and given the opportunity to reschedule without a cancellation/no show fee.

_____ Initial here that I have read, agree with, and understand the above statements.

Travel Fee

RPT travels to treat patients in an area within Los Angeles County. Whenever the schedule permits, a therapist will travel outside this area to service patients for an

additional **travel fee of $50 per visit**. At times, patients on the outskirts of this service area may qualify for the travel fee due to the distance from the therapist's point of origin. RPT and therapists retain the right to decline admitting or treating patients who live outside the service area or decline patients who live in conditions that are not suitable for therapy due to safety reasons.

_____ Initial here that I have read, agree with, and understand the above statements.

Cancellations and Missed Appointments

If the patient is unable to keep an appointment, please contact your therapist as quickly as possible, preferably 24 hours prior to your scheduled visits. Visits that are cancelled within two hours prior to visit time, or are not cancelled at all, will be billed $75 due to scheduling / traveling inconveniences.
In the case of a true medical emergency, the cancellation fee will be waived.

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Informed Consent to Treatment

Physical Therapy involves the use of many different types of treatment approaches and modalities. The patient should understand that a Physical Therapy diagnosis is not a medical diagnosis by a physician or based on radiological imaging and that health plan or insurer might not cover such services.
As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict the patient's response to a certain modality or procedure. It is impossible to predict an individual patient's reaction to a treatment may be, nor can it be guaranteed that the treatment will help the condition the patient is seeking treatment for. There is also a small risk that the treatment may cause increased pain or aggravate previous existing conditions. The patient has the right to ask the physical therapist what type of treatment she is planning based on medical history, diagnosis, symptoms and testing results. The patient may ask the therapist about the potential risks and benefits of a specific treatment. The patient has the right to decline any portion of the treatment at any time before or during the treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If the patient has any questions regarding the type of exercise that he/she is performing, and any specific risks associated with these exercises, the therapist will be glad to answer them. I acknowledge that an RPT therapist has explained my treatment program, and my questions have been answered to my satisfaction. I understand the risks associated with Physical Therapy as outlined to me, and wish to proceed.

_____ _____
Signature Date

Patient Privacy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.
I have been informed by Amanda J. Rosette PT, DPT of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that RPT has the right to change her Notice of Privacy Practices from time to time and that I may contact RPT at any time to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that RPT restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand RPT is not required to agree to my requested restrictions, but if the owner does agree than she is bound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that RPT has acted relying on this consent.

_____ Initial here that I have read, agree with, and understand the above statements.

If the patient is concerned that Amanda J. Rosette PT, DPT has violated privacy rights or if the patient or caregiver disagree with any decisions we have made please contact Dr. Rosette, owner, by phone at 424-243-5261 or email at rosettephysicaltherapy@gmail.com.

I hereby acknowledge to the use and disclosure of my personal health information for the stated purposes and the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____ Initial here that I have read, agree with, and understand the above statements.

Patient Media Release

I hereby grant permission to the staff of RPT to use images, likenesses, audio or any other data (heretofore referred to as “Media”) obtained through my treatment for instructional, educational or research purposes. This included all photos, videos, audio recordings, charts, graphs, analysis or any other data obtained by or submitted to the staff of RPT during my treatment. The media may be used in any professional manner that RPT deems necessary and I understand that the media belongs to RPT and I will not receive any compensation or payment in connection to their use.

I assume the risks involved in releasing this information and release RPT, employees, and contractors from any and all liability that could arise from the use of this Media.

_____ Initial here that I have read, agree with, and understand the above statements.
_____ Initial here that I wish to opt out of media participation.