DORSET PHYSIO 3155 Rt-30 Dorset, VT 05251 Phone 802-867-7056 Fax 802-440-0280

DORSET PHYSIO PHYSICAL THERAPY PLC CONSENT & RELEASE FORM

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA PRIVACY POLICY

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of services at Dorset Physio Physical Therapy. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. This consent shall be ongoing for a period not to exceed one year. I (*print name*) _____ have read this form and fully understand and accept its terms and conditions.

PATIENT RESPONSIBILITY

I acknowledge that it is my responsibility to understand the coverage and limits of my insurance policy. I understand that I am responsible for co-payments, deductibles, and/or patient balances as directed by my insurance policy. In the event that my insurance denies payment I understand that I am responsible for my bill. If you are currently receiving home health care you cannot be seen by Dorset Physio Physical Therapy at the same time. In the case this happens, and the insurance denies, you will be responsible for the bill. I understand that if I have questions about my bill, I may speak with Kelly Gaiotti, DPT owner about my bill. My therapist is not responsible for knowing, giving advice about or reviewing my coverage.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to Dorset Physio Physical Therapy and understand that I am financially responsible for non-covered services. I understand that if Dorset Physio Physical Therapy does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize the physician and/or Dorset Physio Physical Therapy to release any information necessary in order to process any and all claims. All of the information provided is correct and true to the best of my knowledge.

NO SHOW/CANCELLATION POLICY

In addition, I understand and agree with Dorset Physio Physical Therapy's "no-show," / cancellation / rescheduling policy: I will be charged a $50.00 fee in the event that I miss an appointment, cancel and / or reschedule in less than a 24-hour period. Step Down Program Clients will be charged for a full session.

Signed: _____ Date: _____
Print Name: _____
If not signed by the patient, please indicate relationship: _____
Name of patient: _____

For office use only:

Signed form received by: _____

Acknowledgment refused: Y N Efforts to obtain: _____
Reason for refusal:
_____