Appointment Reminder/Communications: By providing your contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

1. **What influenced your decision to come to Redbud Physical Therapy?**
   Friend/Relative Radio TV Newspaper Phone Book Other: __________________
2. **Are you presently under the care of Home Health? Yes No**
3. **Are you under the age of 65, covered by Medicare and disabled? Yes No**
4. **Is this a Workers Compensation claim? Yes No * Is this condition a result of a motor vehicle accident? Yes No**
5. **Have you had physical therapy or Chiropractic services this year? Yes No If yes, list dates: __________________**

Consent for treatment: I hereby consent to evaluation and subsequent patient care which, in the judgment of my therapist and/or physician, may be considered medically necessary or advisable while a patient of Redbud Physical Therapy.

Authorization to discuss medical information with family or friends: Do you wish for us to verbally discuss your information with family members or friends? **Yes No** Please indicate below who you are authorizing us to speak with and what we may discuss. (i.e. Financial, Scheduling, Diagnosis &/or Treatment) *This authorization shall remain valid until revoked by me in writing.*

1.

2.

Guaranty of Account: I hereby authorize payment of medical benefits to Redbud Physical Therapy for services rendered and accept total responsibility for all services not paid in full by my insurance company or payer source. I understand that I am responsible for paying copays, deductible, and coinsurance at each service as applicable.

Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices for Redbud Physical Therapy.

Home Health Attestation (For Medicare Patients Only): It is our desire that patients who receive care at Redbud Physical Therapy know what to expect in regard to their insurance coverage. The purpose of this letter is to inform you of Medicare coverage limitations when Home Health Services and Outpatient Physical Therapy are performed at the same time. Please be aware that Medicare will not pay for outpatient physical therapy if someone is coming to you home to provide any kind of medical care or housekeeping. For this reason, we ask that you acknowledge the following statements by **initialing each item**.

1. _______ I am not currently receiving Home Health Services
2. _______ If any physician places me on Home Health during my care with Redbud Physical Therapy, I will notify Redbud Physical Therapy immediately.
3. _______ In the event that I do not make Redbud Physical Therapy aware that I am receiving Home Health services, I do accept financial responsibility for the services rendered.

Attendance Policy: I understand that attendance at all scheduled physical therapy appointments is vital to my rehabilitation. It is Redbud Physical Therapy's policy that my physician, case manager, insurance adjustor and employer, if applicable, may be notified regarding any no shows or unjustified cancellations. In addition, I also understand that a total of any combination of cancellations or no shows greater than three will serve as reason for discharge from physical therapy services, unless indicated by my physician.

Disclaimer: While Redbud Physical Therapy makes every effort to obtain correct information regarding copay, coinsurance and deductible, we cannot guarantee the information we receive from your insurance company to be completely accurate. I understand that Redbud Physical Therapy cannot be held responsible for information provided to them incorrectly from my insurance company. In addition, Redbud Physical Therapy does not assume responsibility for loss, damage or destruction of patient's personal property, including patient's vehicle. The patient specifically agrees to release, indemnify, and hold Redbud Physical Therapy harmless from and against any and all claims, demands, and/or causes of action of any and every nature related to or arising from any accident, casualty or event involving patient's property which may occur in, on or about Redbud Physical Therapy properties unless such claims shall be based on intentional, negligent or malicious acts by Redbud Physical Therapy or its employees.

____

Patient Signature & Date: **Parent or legal guardian signature & Date (if patient is a minor):**

Guarantor of Account for minor patient (please print): Legal Name: ____

Relationship to minor patient: _________________ Date of Birth: ______________ Social Security Number: ________________