Anchor Physical Therapy, PLLC Phone 518-889-2624 Fax 518-240-3191
Audrey Paslow PT, DPT, NCS. Info@AnchorPTNY.com

Anchor Physical Therapy's New Patient Consent & Statement of Financial Responsibility

Welcome to Anchor PT – a small, boutique private practice specializing in outpatient care with a neurologic-based approach. Please read the following policies and procedures carefully, and sign below. All areas must be initialed and signed before treatment can begin.

Consent for Treatment

I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

I acknowledge and agree to treatment as outlined above: _____ (Initial here)

IF minor, I _____ (print name) as their legal guardian, acknowledge and agree to this treatment as outlined above: _____ (initial here)

Appointment attendance policy

I understand the importance of attending therapy consistently 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 the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow repeat in subsequent weeks. I understand I must schedule individual appointments for each visit.

I agree to provide at least **24 hours' notice** when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment shall result in **a cancel/no show charge of $30. I understand I must pay this fee immediately.**

I acknowledge and agree to this policy: _____ (Initial here)

Responsibility For Payment

All payments/co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Anchor Physical Therapy, PLLC, I am financially responsible for payment of my bill.

I acknowledge that it is my responsibility to provide Anchor Physical Therapy, PLLC with current insurance information and to *familiarize myself with my insurance plan and its policies*. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My

health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

When you provide a check as payment in the clinic, you are certifying that you are owner of the account from which the check is written, and you authorize us to use the information from your check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day and you will not receive your check back from your financial institution.

Name: _____ Signature: _____

Full Address: _____

Please note that refusal to sign this form does not change responsibility for payment in any way.

In the event of a deductible plan, I consent to provide a credit card for billing purposes, which will be placed on file and the patient responsibility, as determined by my insurer, will be charged once benefits information is received by the clinic.

I acknowledge and agree to this policy: _____ (Initial here)

Assignment of Benefits

I hereby assign to Anchor Physical Therapy, PLLC, all my rights and claims for reimbursement for all services rendered to me by Anchor Physical Therapy, PLLC, under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

I acknowledge and agree to this policy: _____ (Initial here)

Access To and Release of Health Information

I understand that Anchor Physical Therapy, PLLC 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 other health care professionals caring for me.

I authorize my clinician(s) and Anchor Physical Therapy, PLLC administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Anchor Physical Therapy, PLLC's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

Additional individuals who may receive personal health information, scheduling, or billing information related to my care: _____

I acknowledge and agree to this policy: _____ (Initial here)

COMMUNICATION

I grant consent to the release of appointment information left in a voicemail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

I acknowledge and consent to this information being shared via text or voicemail:

_____ (Initial/sign here)

_____ (Phone number)

CONSENT FOR EMERGENCY CONTACT INFORMATION

Person to contact in case of an emergency:

Name: _____
Telephone Number: _____
Relationship: _____

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.

_____ _____
Signature of Patient or Legally Responsible Person Date Signed:

_____
Printed Name of Above

Anchor Physical Therapy, PLLC, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.