Alternative Back Care Physical Therapy *Achieving relief one back at a time*

Welcome!

Alternative Back Care Physical Therapy is pleased to work with you for your health care needs. Thank you for choosing us to provide your Physical Therapy care. The following statements are our policies which we require you read, agree to and sign prior to any treatment. Any questions, please ask.

Treatment Consent

This is consent for use of Physical Therapy techniques, general modalities, IASTM, soft tissue massage, cupping and the Leveling Technique®. Open communication with the therapist about how treatment is going is key to your success. If you experience discomfort during manual therapy, it is vital that you let your therapist know right away so a different approach can be used. If you have therapist preference, let the front desk know. We always welcome your feedback.

Notice of Privacy Practices

Our commitment here at Alternative Back Care Physical Therapy is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information. It may be necessary to share information with other health care providers or business associates. The following are examples of where information may be shared:

- During treatment, we may find it necessary to discuss your treatment plan with colleagues or referring physicians
- For payment purposes, we may need to speak with your insurance company regarding billing issues or questions regarding your treatment

We here at Alternative Back Care Physical Therapy are committed to following all federal, state and local laws and regulations regarding privacy practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with written authorization. Ask the front desk for the form to provide written authorization. Written authorization can be revoked at any time, as allowed by the state. If you have any questions, comments or would like additional information, please ask the front desk.

Insurance

Your insurance is a contract between yourself and your insurance carrier. We will, as a courtesy, bill your insurance, look up benefits, and help you receive the maximum allowable benefit under your policy. See attached insurance sheet for a breakdown of your insurance benefits.

Cancellation and No Show Policy

We require 24 hours notice for any cancellations. This gives us time to adjust our schedule accordingly. If we do not get 24 hours notice or if a patient no shows to an appointment we reserve the right to charge $50 for a missed Physical Therapy appointment and $25 for a Massage Therapy appointment. Repeated missed appointments without notice can cause you to be discharged or moved to day of scheduling.

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Medical Record Fees

Patients are entitled under Federal law to have access to their PHI, and we follow all rules and guidelines for compliance of patient rights. There is a reasonable, cost-based fee.

Appointment Reminders

As a courtesy, ABC PT provides reminders to our patients about upcoming appointments. How would you like for us to contact you?

- ☐ Email: _____
- ☐ Text:_____ Cell Phone Provider_____

ABC PT values your privacy. Please select if you would prefer us to leave detailed phone messages.

- ☐ I authorize ABC to leave detailed phone messages at this number:_____
- ☐ Please do not leave medical details on any of my answering machines. Details will be only related to appointment times, clinic name and a call back number.

I have read and acknowledge ABC Physical Therapy's Policies

Signature:_____ Date:_____

Consent for Research (Voluntary)

We are striving to advance the Physical Therapy profession in order to provide exceptional care to all our patients. We are researching and publishing data about ABC PT's treatment methods for neck pain, back pain and sacroiliac joint dysfunction. We are asking permission to collect data to gain a better understanding of the impact of specific therapeutic interventions on pain and disability.

- Participation is *voluntary*
- Your personal information (name, address, phone, SSN, PHI) will be kept confidential
- Information gathered may include, but not limited to: age, sex, diagnosis, total care duration, number of sessions attended, pain ratings, outcome measure scores, relevant health and medical history, symptom behavior, assessment tests and results, types of joint mobilization and therapeutic exercises and interventions
- Information collected may be presented in reports, presentations and/or publications as anonymous, grouped data
- Please note that while your name and other personal information will not be used, nor published, complete anonymity cannot be guaranteed.

I certify that I have read the Consent for Research and I understand its contents. Any questions I have pertaining to this consent have been answered and I consent to have my information used for research.

Signature:_____ Date:_____