Broadway
Physical Therapy &
Sports Rehabilitation, LLC

CONSENT FOR MEDICAL TREATMENT

I herby authorize Broadway Physical Therapy and Sports Rehabilitation, LLC to administer and perform procedures deemed necessary or advisable in the treatment of this patient.

Please initial_____

CONFIDENTIALITY

Patient privacy and confidentiality is important to us. Due to the nature of our facility (open gym area), conversations may be overheard by other patients and some information may be shared. If you have information that you would like to discuss with the therapist in private, please be sure to bring this to their attention. If you have any other concerns about confidentiality please be sure to let us know.

Please initial_____

AGREEMENT FOR FINANCIAL RESPONSIBILITY

I hereby authorize payment directly to Broadway Physical Therapy and Sports Rehabilitation, LLC, by my insurance carrier, of benefits otherwise payable to me, such payment not to exceed Broadway Physical Therapy's regular charges for the services performed. I understand that I am financially responsible to Broadway Physical Therapy and Sports Rehabilitation, LLC for charges not paid under this agreement.
A fee of 1.5% of the existing balance may be added each month to all accounts over 60 days old. In the event your account is turned to collections an additional $200.00 handling fee will be applied.

Please initial_____

MEDICARE PATIENTS ONLY REGARDING PHYSICAL THERAPY BENEFITS

Medicare may not pay for physical therapy in excess of $1980.00 per calendar year. If costs exceed the benefit of $1980.00 then it may become your responsibility. Please let us know if you have had therapy this year.

Please initial_____ Therapy this year? Yes___ No___

NO SHOW FEE/CANCELLATION POLICY

Broadway Physical Therapy requires a 24 hour notice for appointment cancellations. You may be charged a **$50.00 cancellation fee** for appointments that are cancelled with less than a 24 hour notice.

Please initial_____

REMINDER CALL AUTHORIZATION

A Reminder for appointments is a service that we provide. Many patients appreciate this service, however, under new HIPAA regulations we understand that leaving specific information regarding your personal health may be a violation of your privacy. Please check the appropriate boxes below. We will do our best to provide the service that meets your needs. Please choose one option:

Phone:_____ Text:_____ Email:_____ None:_____

Date:

Patient name_____ Patient signature_____
(Please Print)

Parent/Guardian name_____ Parent/Guardian signature_____
(Please Print)