Total Care Physical Therapy and Wellness, LLC
Phone: (407) 476-9233 Fax: (321) 340-3555

Informed Consent to Treatment

Physical therapy is a patient (client) care service that is provided in order to manage a wide variety of conditions. Physical therapy services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Total Physical Therapy and Wellness, LLC does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Physical therapy may require the physical touching of your body in all locations, including sensitive or private areas in some instances. You consent to and agree to this. Furthermore, there is a possibility that the physical therapy treatment may result in aggravating existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties including any provider named below.

______________________________	______________________________
Signature	Date

Name (print)____

______________________________	______________________________
Relationship to Client	Witness

Direct Access to Therapy

Florida law permits direct access by clients to physical therapy services for up to 30 days without a physician order. Please provide the name and phone number of a medical provider who can issue a referral/prescription/order for specialized physical therapy within 30 days of starting your evaluation. This medical provider can be an Medical Doctor (M.D.), Physician Assistant (P.A.), osteopathic physician (D.O.), Advanced Practice Nurse (A.P.N.), Chiropractic Physician (D.C.) or Doctor of Podiatric Medicine (D.P.M.) They can fax an order to Total Care, you can bring it in with you, or we can request one after your initial evaluation with us.

Medical Provider's Information:

Name: ___________________________________ Phone:_______________________________

Address:

____

Consent to Email / Text for Appointment Reminders Or Healthcare Matters

By initialing and signing below I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Total Care Physical Therapy and Wellness LLC.

1. ____ (Client Initials) I consent to receive text messages from the practice on my cell phone and any number forwarded or transferred to that number, or e-mails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is__________________________________.

The e-mail that I authorize to receive e-mail messages for appointment reminders and general health reminders/feedback/information is____.

2. ____ (Client Initials) I hereby revoke my request for future communications via text messages.

3. ____ (Client Initials) I hereby revoke my request to receive any future communications via email.

___________________________________ ___________________________________

Signature Date

Name (print)____

___________________________________ ___________________________________

Relationship to Client Witness

Client Financial Responsibility Agreement

I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist, and agree to pay for it. I understand that the client is responsible for all fees and charges incurred regardless of insurance coverage.

Total Care Physical Therapy and Wellness, LLC (Total Care), provides services delivered in the privacy and comfort of your own home. In doing so, Total Care is able to optimize treatment time while providing you with our dedicated attention and effort. This allows us to be completely focused on you, and not be influenced by the directions of a third-party payer (such as an insurance company), and allows us to deliver healthcare with the highest degree of pride and professionalism. With the exception of Medicare, Total Care chooses to not contract with insurance companies, and is considered to be an out of network provider. We believe that having contractual agreements with insurance companies imposes limitations on your care.

_______ **Initial-for clients holding commercial insurance choosing to pay cash for services.** By initialing this section and signing this Financial Responsibility Agreement you are agreeing that Total Care will not be submitting a claim or bill to your insurance provider for potential reimbursement. You, yourself, will be expected to make payment IN FULL at the time of the service. Total Care is happy to provide you with an invoice/statement for you to file on your own, should you so desire. **However, It is your responsibility to understand your insurance policy and their requirements for reimbursement. It is understood that reimbursement from your insurance in whole or in part, is not guaranteed.**

_______ **Initial-for clients holding commercial insurance and choosing to have Total Care submit a claim to the insurer on your behalf.** You acknowledge and agree that you are still responsible for any co-pays or deductibles required by your insurance, and payment of these to Total Care is to be made at time of service.

_______**Initial-for clients if Medicare is being billed for your PT services.** You agree to take full responsibility for any and all charges not covered by Medicare or which are denied by Medicare for any reason. Federal Regulations require that a Medicare eligible client acknowledge and sign an Advanced Beneficiary Notice (ABN) waiver when engaging in services not covered by Medicare or which require private payment by the client. You agree that you will do this.

Policy on Cancellations and Missed Appointments

In the event that the client is unable to keep a scheduled appointment, please contact your Total Care Physical Therapy and Wellness, LLC (Total Care), as quickly as possible. Scheduled visits that are canceled within two (2) hours prior to visit time or which are not canceled at all will be billed $50.00 because of the lost appointment time and scheduling and travel inconveniences. E-mail may be used to communicate a scheduled appointment cancellation, but only if the e-mail is sent twenty-four (24) hours prior to the appointment start time, also, you should obtain and keep a copy of your e-mail and a “read receipt” showing that it was received and read.

_____ **(Initial) I have read, understand and agree to the above policy.**

Appointment Times and Scheduling

Total Care Physical Therapy and Wellness, LLC (Total Care), will contact the client or the client's care-giver prior to the appointment to confirm the appointment. Total Care will make every effort to arrive on schedule. However, because we cannot anticipate what every person will need, we will take whatever time is necessary to give each and every client the best care that is needed. As we make home visits, one cannot foresee delays and obstacles that may arise such as accidents, parking problems, heavy traffic, unforeseen road conditions or personal emergencies. For this reason we will have a window of sixty (60) minutes before or after the appointment time of arrival. If the therapist is running more than sixty (60) minutes late then the client will be called and given the opportunity to reschedule without a cancellation or no show fee.

_____ (Initial) I have read, understand and agree to the above policy.

Travel Reimbursement Fee

Total Care Physical Therapy and Wellness, LLC (Total Care), has its employed and contracted professionals travel to treat its clients within the East Orlando area. Whenever a professional's schedule permits, he/she may travel outside the regular area of service to provide service to clients; however, the client's payment will include an additional fee for the additional travel required. At times, clients on the outskirts of the service area may be required to pay the travel reimbursement fee due to the distance from the therapist's point of origin. Total Care retains the right to decline treating clients who live outside the service area. Total Care may also decline to treat clients who live in conditions that our therapists believe are unhealthy, unsafe, unsanitary or unsuitable for the delivery of their services for any reason.

_____ (Initial) I have read, understand and agree to the above policy.

_____ (Initial) I live outside of the Total Care Physical Therapy and Wellness, LLC, service area, and agree to pay the travel reimbursement fee of $25.00 per visit.

I HAVE READ AND AGREE TO THE ABOVE POLICIES IN EXCHANGE FOR THE SERVICES PROVIDED TO ME BY TOTAL CARE.

________________________________ ________________________________
Signature Date

Name (print) ____

________________________________ ________________________________
Relationship to Client Witness

NOTICE OF PRIVACY PRACTICES FOR TOTAL CARE PHYSICAL THERAPY AND WELLNESS, LLC

Please read the following:

At Total Care Physical Therapy and Wellness, LLC (Total Care), we are committed to treating and protecting your medical information. The creation of a medical record detailing the care and services you receive helps us provide you with quality health care.

This Notice of Privacy Practices describes the health information we collect and shows the ways in which your medical information can be used. You must sign and date the Notice of Privacy statement before you begin treatment.

Each time you visit Total Care, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan of care for your treatment. This information is often referred to as your health or medical record.

Although your health record is the physical property of Total Care, the information belongs to you. You have the right to:
- Obtain a copy of the notice of privacy practices upon request
- Inspect and copy your health record
- Make changes in your health record
- Make a list of who your medical record was shared with
- Request communication of your medical record in certain places (for example, you may want us to call you at work instead of home)
- Request a restriction on certain uses and sharing of your information
- Revoke your permission for use or sharing of your medical record except to the extent that action has already been taken

Total Care is required to:
- Maintain the privacy of your medical records
- Provide you with this notice as to our legal duties and privacy practices with respect to your medical records we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a request restriction
- Accommodate reasonable requests you may have to communicate your medical records by alternative locations

We reserve the right to change our practices and to make the new provisions effective for all medical records we maintain.

`We will not use or share your medical record without permission, except as described in this notice. We will also discontinue the use of the Notice of Privacy Practices and share your medical record after we have received notice in writing that you have revoked your Permission.

The law allows us to use your medical records without your permission for treatment, payment, and business operations. The following are some examples: client billing, third party billing, quality of care and improved services, other specialty care, caregiver/family member notification/communication, research, organ and tissue donation, marketing, fundraising, Food and Drug Administration (FDA), Workers Compensation, law enforcement, and public health.

Federal law makes provision for your medical records to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member of business associate believes in good faith that we have engaged in unlawful conduct of have otherwise violated professional or clinical standards and are potentially endangering one or more clients, workers, or the public.

If you have any questions or requiring additional information, or if the client is concerned that Total Care Physical Therapy and Wellness LLC has violated privacy rights or if the client or caregiver disagree with any decisions we have made, please contact Marcy Frederico, Owner, Total Care Physical Therapy and Wellness LLC at 407-476-9233 or
Email: marcy@totalcarePTandwellness.com

By entering your name below, you are effectively providing your signature agreeing to the terms and conditions above.

______________________________ ______________________________

Signature Date

____

Name (print)

______________________________ ______________________________

Relationship to Client Witness