Consents

ProActive
REHABILITATION & WELLNESS

1. Insert Your Full Name

First _____ Last _____

Let's be honest, everyone hates attendance policies. We hate giving them out, and you all hate signing them and feeling like you're being held hostage by a policy that's more designed around the clinic's convenience rather than your own. But here's the deal: if you aren't committed to your therapy, wellness, or performance program, you likely won't experience the benefits, improvement, or pain relief you want and need. You get out what you put in. We promise to show up, 100%, for you. That being said, this isn't a one-way street. It requires that you make some commitments as well; commitments to us & our programs, and commitments to yourself: During your first visit, we will discuss treatment options and set goals with you. We will be flexible and make every effort to schedule appointments at times that are convenient for you. We can also give you a printout to remind you of your appointments. Here are some basic commitments we expect from all of our patients and clients: 1) Please arrive on time for your appointment so that you may be given the full benefit of your scheduled treatment. 2) Please plan to attend every scheduled therapy appointment. We realize that at times, this may not be possible, and you may need to reschedule your appointment. Please note that we ask you to call the office at least 24 hours before the scheduled appointment time. 3) If you call to reschedule an appointment with less than 24-hour notice, it is considered a Same Day cancellation. Same Day Cancellations may result in discontinuation of services, if they occur regularly. 4) Failure to show for an appointment or calling to cancel your appointment after the time your appointment was scheduled, is considered a "No Show". A "No Show" will result in a $15 charge. This charge covers the administrative costs of rescheduling an appointment and adjusting the schedule. Two "No Show" appointments will result in a discontinuation of your therapy services. Multiple Same Day Cancellations or the inability to attend regularly scheduled appointments may result in discontinuation of therapy services at the discretion of the clinician. If your services are discontinued, your referring physician/provider will be notified and you will be required to get a new referral to resume physical therapy. We thank you for choosing ProActive Rehabilitation & Wellness, LLC. We are looking forward to partnering with you to help you reach your goals. Your therapist will be happy to discuss this policy with you if you have any questions or concerns, The Staff at ProActive Rehabilitation & Wellness

_____ _____

Signature Date

Consent for Treatment & Provision of Services: I have a condition requiring therapy intervention, wellness & health promotion, or performance program participation, and consent to the delivery of such care and/or services. In order to improve my condition, I consent to enter ProActive Rehabilitation & Wellness programs for evaluation and treatment. I request and authorize the licensed staff of ProActive Rehabilitation & Wellness, LLC to render treatment, and to perform appropriate procedures that my referring provider may deem reasonable and necessary for my diagnosis. I understand that my clinical care and treatment may be provided by a licensed clinician, either a licensed therapist or assistant. I am aware that there are certain risks involved with any therapy, wellness & health promotion, and/or performance program. Every effort is made to minimize my risk by continuous assessment of my condition throughout my participation in the program. I will inform my therapist or clinician of any changes in my medical condition, or medications, as they may necessitate change in my individualized program. I will stop any procedure or activity and inform my therapist or clinician of any symptoms of pain, fatigue, shortness of breath, dizziness or nausea that may develop during my treatment or session.

Signature Date

Privacy Notice Acknowledgement: As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby acknowledge that I have had the opportunity to review a copy of ProActive Rehabilitation & Wellness LLC's "Notice of Privacy Practices". I understand that I am responsible to read this Notice and notify Proactive Rehabilitation & Wellness, LLC, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. ProActive Rehabilitation & Wellness, LLC has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times. I am aware that ProActive Rehabilitation & Wellness, LLC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains. ProActive Rehabilitation & Wellness, LLC will provide me with a copy of its most recent Notice upon my request.

Signature Date

Requirement to Provide Proof of Current Insurance and Obtain Referral: I understand that it is my responsibility to provide ProActive Rehabilitation & Wellness with a copy of my current insurance card(s) and to obtain a referral from my Primary Care Physician's office (if required by my insurance or by state law). If I do not have insurance, I will be considered a Self-Pay patient and I am financially responsible for the total amount of the services provided. I will notify ProActive Rehabilitation & Wellness immediately upon any changes in my insurance.

Signature Date

Insurance Waiver: I understand that if I do not have a copy of a current insurance card and valid referral, if required, ProActive Rehabilitation is not obligated to see me, but if I still wish to be seen, I can be seen as a "Self-Pay" patient. I agree that neither Proactive Rehabilitation & Wellness nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance.

Signature Date

Payment & Balances: Co-payment is due on each day services are rendered. There is a $35.00 charge for all returned checks to cover administrative costs. When an account has received two returned checks, it will automatically be placed on a "cash" only status. For your convenience, we accept cash, checks, credit cards and debit cards. In the event that a patient balance remains open for 180 days, that account will be placed in collections. A collections fee of 35% of the outstanding balance will be charged for the administrative cost of collecting outstanding balances.

Signature Date

Assignment of Benefits: I hereby authorize and assign all payments and/or insurance benefits for therapy services rendered to the patient, directly to ProActive Rehabilitation & Wellness, LLC. I hereby authorize ProActive Rehabilitation & Wellness to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

Signature Date

Attire: For access to particular body parts being treated, loose fitting clothing is recommended. For pool/aquatic therapy visits, pool attire is required.

Signature Date

Adult Supervision: Those under the age of 16 receiving treatment at our facility must be accompanied by a parent or legal guardian during each service appointment.

Signature Date

Other Information: I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records, not covered by my insurance plan.

Signature Date

Optional Media/Marketing Consent: I authorize ProActive Rehabilitation & Wellness LLC and its employees, agents, and authorized representatives, to use and/or disclose my Protected Health Information contained in any photographs, videos, medical and physical therapy records, and/or audio recordings for the following purposes: Use in internal and external advertising, marketing, public relations or collateral materials, including but not limited to posting on ProActive Rehabilitation & Wellness, LLC's website and social media sites. Use in news releases or stories, including television, newspaper, or radio broadcasts. Use in internal and external education and/or training programs for the public and/or medical professionals, including but not limited to use on public websites and social media sites. Use in subscription to an email newsletter, CRM software, and other marketing communication avenues. I understand that, outside of this agreement, my name & personal contact information will never be disclosed unless prior written authorization is obtained, and that my identity will be anonymized. I provide my authorization knowing that: The Protected Health Information that is used or disclosed pursuant to this authorization, including Protected Health Information contained in any photographs, videotapes, or interviews, may be subject to re-disclosure by the recipient(s) and may no longer be protected by HIPAA or other state or federal laws. Signing this authorization is voluntary. I have the right to refuse to sign this authorization. My treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on my provision of this authorization. I understand that I can revoke or cancel this authorization at any time by sending written notice to: ProActive Rehabilitation & Wellness, LLC 2103 Reedale Ave. Augusta, GA 30906 If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization. I am entitled to receive a copy of this Authorization upon request. Unless I revoke this authorization, it will expire 30 months from the date signed below.

_____ _____

Signature Date