Wisconsin Orthopedic Physical Therapy Authorization Form

Release of Information & Consent for Treatment:

I am aware of my diagnosis and wish to receive treatment at Wisconsin Orthopedic Physical Therapy LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I authorize Wisconsin Orthopedic Physical Therapy LLC and its subsidiaries and affiliates to release information verbal and written, containing in my medical record, and other related information, to any persons as it relates to my treatment and/or payment for services provided.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Wisconsin Orthopedic Physical Therapy LLC, its subsidiaries, and/or affiliates. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Financial Policy

Wisconsin Orthopedic Physical Therapy offers the service of billing your insurance company for care you have received from one of our therapists. It is your responsibility to notify us of any changes in your insurance coverage.

Our policy is to have a copy of your credit card on file. If you have a balance over 90 days we reserve the right to charge your card for this balance. We will notify you before we do so. If you choose not to provide a copy of your credit card, we will run a payment today of $100 to use towards any balance. If you are uninsured, or have chosen to self-pay, payment is due in full on the date of service or in advance. For our insured patients, co pays are due on the date of services provided to you in the office.

The fees we charge for services are usual and customary for this area. Your health insurance policy may base its allowanced on a fixed fee schedule that may or may not coincide with our usual fees. You should be aware that different companies may vary greatly in the type of coverage available. Ultimate responsibility for payment for service rendered is yours.

We want to *thank you* for choosing us as your health care provider. In order to give you and our patients the best possible care, we request that you review our policy regarding missed and/or cancelled appointments. **A missed appointment is when you fail to show up an an allotted appointment time, without a phone call or cancellation notice of at least 24 hours. A $50 fee, billed directly to you, will be assessed for each appointment that fails to comply with this policy.**

If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorization, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

If you have any questions regarding your benefits, limitations, or denials please call your insurance company. If the information provided by my insurance company is not accurate or the insurance company changes, I will be responsible for payment for services.

I hereby understand and agree to the terms listed above regarding Wisconsin Orthopedic Physical Therapy's financial and billing practices.

Patient Name: _____Signature:_____Date:_____