Koop Physical Therapy, P.C.
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Koop
Physical Therapy

DISCLOSURE AND CONSENT

Medical and Therapeutic Procedures

To the patients: You have the right, as a patient, to be informed about your condition and the recommended therapies to be used so that you may make the decision whether or not to undergo the treatment after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

_____ ***Initial***

Consent to Treat: I understand that as a Patient I have the right to make all decisions regarding my care. I voluntarily request KOOP Physical Therapy and Niki Koop as my therapist, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition. I also understand that no warranty or guarantee has been made to me as to results or cure. I understand that my therapist may discover other or different conditions which require additional or different procedures than those planned. I authorize my therapist, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

_____ ***Initial***

No Show/Cancelation Fee: We reserve the right to charge a $50 fee for No shows or cancelations without 24 hourrs notice.

_____ ***Initial***

Risk and Emergency: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the physical therapy.

_____ ***Initial***

Authorization to Release Information: I authorize KOOP Physical Therapy to release any and all healthcare information as necessary to (a) obtain payment from my Payors for my healthcare, (b) to conduct utilization review, peer review, and quality assurance, and (c) to other healthcare providers that will assist with my care. I understand that this information will identify me and may relate to my history, diagnosis, treatment or prognosis; it will also include where applicable, psychiatric, alcohol abuse, drug abuse, specific laboratory results of HIV or the diagnosis of AIDS. I understand that in the event of a healthcare worker being exposed to my blood or bodily fluids, that my blood may be tested for the HIV antibody and other communicable diseases.

_____ ***Initial***

Financial Authorizations: I authorize all payors to pay directly KOOP Physical Therapy for therapy services provided. I assign to KOOP Physical Therapy my right to receive payment from third party payors. Third Party payors include anyone from whom benefits are, or may become payable to me for services provided.

_____ ***Initial***

Receipt of Information: I acknowledge that I have received the "Notice of Privacy Practices" and a copy of "Patients Rights, Responsibilities and Healthcare Choices" from KOOP Physical Therapy. I certify this for has been fully presented and explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____ ***Initial***

Financial Responsibilities: I understand and agree that I am responsible for payment of all charges that result from the care provided to me. I Agree to pay these charges including payments not paid by my insurance company payors within 120 days. I understand that it is my responsibility to submit accurate insurance information on all dates of service and to comply with all request of my insurance company within a timely manor to ensure payment is made with in 120 days. I understand that if I am covered by Medicare / Medicaid, my obligation under this section may be limited by law.

_____ ***Initial***

Property: I understand that KOOP Physical Therapy does not assume responsibility for any personal property.

PATIENT/ OTHER LEGALLY RESPONSIBLE PERSON (signature required):

_____ Date and Time:_____

Name:_____ Relationship _____