PLYMOUTH BAY ORTHOPEDIC SPORTS THERAPY

PLYMOUTH OFFICE
41 Resnik Road
Plymouth MA 02360
Phone: 781.934.7292

Name: _____ Date of Birth: _____

CONSENT FOR FINANCIAL COMMUNICATION

Plymouth Bay Orthopedic & Sports Therapy may bill my insurance company for services provided to me. I understand my therapy benefits and agree to pay any patient balance as outlined in my insurance policy. I understand that I may be responsible to pay for any co-payment, coinsurance or deductible amounts assessed by my insurance company. I understand that, if required, it is my responsibility to obtain an insurance referral from my primary care physician. I may be asked to sign a waiver of liability if I choose to receive services without an insurance referral on file. I understand that any information about my outpatient therapy benefit is a quote of benefits and is not a guarantee of coverage or payment. I understand that I will be notified if any services may not be covered by my insurance policy. I agree to pay for any services not covered by my insurance company, including but not limited to – no referral on file, exhausted plan benefit or non-covered services.

By signing below, I understand the Consent for Financial Communication

_____ _____
Signature of Patient/Legal Guardian Date

ATTENDANCE, CANCELLATION, AND NO-SHOW POLICY

_____
Initials

I understand attendance is expected and vital to achieving wellness goals. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment, and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel / no show charge of $35.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPPA)

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

RIGHT TO REVOKE: You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to Plymouth Bay Orthopedic & Sports Therapy. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I hereby give the following individuals permission to receive information from this office on my behalf.

Name of Person: _____ Relationship to me: _____

Name of Person: _____ Relationship to me: _____

On this day, ___ / ___ / ___, I have had full opportunity to read and consider the contents of this Consent form and I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____ _____
Full name of Authorized Representative - Please Print Relationship to Patient Date