COMPASS
PHYSICAL THERAPY SPECIALISTS
Moving you in the right direction.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:
I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to Compass Physical Therapy Specialists, PLLC (Compass PT) for unpaid charges. I agree to pay Compass PT for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including, but not limited to, court costs and actual attorney fees incurred by Compass PT in collecting this account. **Initials_____**

CONSENT FOR TREATMENT:
Knowing that I have a condition requiring treatment at Compass PT, I do hereby voluntarily consent to such treatment as deemed necessary in the judgment of the physician and therapist. **Initials_____**

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:
I consent for Compass PT to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a patient information face sheet, physician orders and selected information to process my durable medical equipment order. **Initials_____**

MEDICAL RECORDS CONSENT:
I consent for Compass PT to release any information contained in my medical record (including photographs, slides, videotapes, audio recordings or other digital images) to schools, other educational programs and other health care providers for continuing care needs or to my insurance company or employer for payment on my account. I understand that this information may include records regarding mental health treatment, social services counseling, alcohol and drug abuse treatment, psychological or psychiatric treatment, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) or venereal diseases. **Initials_____**

CANCELLATION AND NO SHOW POLICY:
Patients are encouraged to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice. Two (2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services. Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on "hold" for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.
I understand the conditions of services at Compass Physical Therapy Specialists, PLLC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
By signing below, I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

_____ _____
Patient/Guardian/Personal Representative Signature *Date*

OFFICE USE ONLY:
Initials_____
Our practice will make a good faith effort to obtain a written acknowledgement of receipt of Notice provided to the patient. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgment was not obtained.
□ Refused to sign □ Physically unable to sign □ Other

Employee signature: _____Date:_____