Physical Therapy Services

Policies & Procedures

Welcome to Vitality Women's Physical Therapy & Wellness, LLC ("Vitality"). Please carefully review, initial, and sign these policies and procedures. They set forth the terms of our relationship as you receive physical therapy from Vitality.

COMMUNICATION

Please tell us how you would like us to communicate with you. By authorizing us to communicate with you by email or text message (signified by checking the corresponding boxes below) or by communicating with us by email or text message, you agree to receive unencrypted emails and text messages from Vitality, which may not be secure.

Home Address: _____

Email Address: _____

Cell Phone: _____ **Okay to leave voicemail?** Yes ☐ No ☐

Other Phone: _____ **Okay to leave voicemail?** Yes ☐ No ☐

Please tell us how we may communicate with you:

	Email	Cell Phone	Other Phone	Mail
Information about care & treatment	☐	☐	☐	☐
Practice announcements & marketing	☐	☐	☐	☐

ALL invoices will be MAILED to the home address listed above on this form.

I agree that appointment reminders will be emailed unless an alternate method is checked here. ☐ ***Text*** ☐ ***Phone***

I acknowledge and agree to this policy. _____ (initial)

533 S. Division, Unit B, Elmhurst, Illinois 60126
Tel.: (331) 215-4164 • Fax (331) 223-9724 • Contact@VitalityWomensPT.com

Notice of Privacy Policies & Procedures

Vitality strives to comply with all state and federal medical privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Health Information Technology for Economic and Clinical Health Act (HITECH), which require us to protect the confidentiality and privacy of your records and personal information.

We have implemented privacy policies and procedures to ensure our compliance with these requirements. This information is summarized on our Notice of Privacy Practices ("Notice"). We will offer you this Notice at our first point of contact with you, and it is also available on our website and upon request. Please ask if you have questions about how we protect your privacy.

I have been offered a copy of Vitality's Notice of Privacy Practices. _____ *(initial)*

I *received* ☐ **or *declined*** ☐ a **paper copy** of Vitality's Notice? _____ *(initial)*

PHI Authorization for Payment & Care Purposes

I authorize disclosure and use of my protected health information and other private information to the extent necessary for Vitality to obtain payment and submit claims on my behalf to my insurance company or other third-party payor, and to the extent necessary to coordinate care with my primary care physician or other treating provider.

I agree and acknowledge that: my insurance company, or other third-party payor, may make payments directly to Vitality and assign Vitality any medical benefits to which I may be entitled, including any benefit under the Employee Retirement Income Security Act of 1974 (ERISA), in consideration for the services provided. If I am not the primary beneficiary of the above insurer or third-party payor, Vitality may communicate with the primary insured and release the information as necessary to facilitate payment.

I understand that I may revoke this authorization at any time by providing written notice to Vitality, except to the extent that Vitality has relied upon it.

I acknowledge and agree to this policy. _____ *(initial)*

Insurance Information for In-Network Physical Therapy Services

You are responsible for verifying your physical therapy insurance benefits, including your benefit limits, co-pays, and deductibles. You are also responsible for determining

if you need prior authorization before obtaining physical therapy and if Vitality is an in-network provider under your plan. The cost of physical therapy services can range from $100 to $300 per session, depending on the types of treatments that we provide.

If we are in-network with your health plan, we will bill your health insurance company directly for our services. Verifying your insurance coverage and benefits is your responsibility. You are always responsible for paying any co-pay and deductible amount required by your insurance.

If we are out-of-network with your plan but you have out-of-network health insurance coverage, you are responsible for paying 100% of our fees at time of service.

After 60 days from the date of service, you agree to pay any outstanding balance. You authorize such charges to the credit card provided.

I acknowledge and agree to this policy. _____ *(initial)*

If you want Vitality to directly bill Blue Cross Blue Shield, please provide the following information and bring your insurance card to your first visit.

Insurance company name: _____ ID: _____

Group number: _____ Insured's name: _____

Relationship to patient: _____ Insured's date of birth: _____

Insured's phone number: _____ Insured's address: ☐ Same as patient or ☐ other: _____

Secondary insurance company name: _____ ID: _____

Group number: _____ Insured's name: _____

Relationship to patient: _____ Insured's date of birth: _____

Insured's phone number: _____ Insured's address: ☐ Same as patient or ☐ other: _____

Self- Payment for Non- Covered or Out- of- Network Physical Therapy Services

If you do not have insurance, if your insurance does not cover our services (e.g., we are out-of-network and your insurance does not cover out-of-network services), or if you do not want us to bill your insurance, you must pay us directly at the time of service. Because of the diversity in health plan benefits and coverage, we cannot guarantee that your insurance will cover our services or that you will receive any

reimbursement. If you decide to file your own claims for out-of-network reimbursement, your insurance may not cover these services, or it may consider them to be subject to lower out-of-network benefits. If you decide to do this, we will provide the code and charge information necessary to file your claim within 6 months of the date of the appointment to which it pertains.

I VERIFY THAT I AM NOT COVERED BY A MEDICARE OR MEDICAID POLICY, WHETHER AS A PRIMARY OR SECONDARY INSURANCE.

I acknowledge and agree to this policy. _____ *(initial)*

PAYMENT GUARANTEE - CREDIT CARD

As a courtesy, we will bill your insurer for our **in-network** services. But if your insurer does not pay within 60 days of our submission of the claim, or if they do not pay the balance in full, you are responsible for full payment. This means that even if we bill your insurance, you are responsible for any fees that it does not pay, including any deductible, co-pays, co-insurance, and credit card or bank fees. Also, some of our fees, such as the cancellation fee, will not be billed to your insurer and will be your sole responsibility to pay.

For any returned check, you agree to pay: your entire balance due, any returned check fees, and a $25.00 charge for Vitality's billing services management of the situation.

I acknowledge and agree to this policy. _____ *(initial)*

You authorize such charges to the credit card provided below. We will save to our file the credit card information for future charges. Please complete the following credit card authorization to cover any above described fees.

Name on Card: _____

Phone: _____ Email: _____

Type of Card (circle): Visa Mastercard AMEX Discover Other: _____

Card Number: _____ Exp. Date: _____ CVC: _____

Card Billing Address (Street/City/State/Zip): _____

_____

The cardholder hereby authorizes the above credit card to be charged for agreed purchases or services, cancellation, and returned check charges, and to be saved to our file:

Signature: _____ **Date:** _____

I decline to provide credit card authorization at this time and I am aware that any overdue balance is subject to collections. _____ *(initial)*

Cancellation & Attendance

We strive to provide you with the highest quality care. For your convenience and to facilitate your care, we have reserved an appointment for you. If you need to cancel or reschedule your appointment, please do so no later than 12:00 p.m. on the business day (Monday through Friday) prior to your scheduled appointment; for Monday appointments, please cancel by 12:00 p.m. on the previous Friday ("Cancellation Window"). Cancellations made outside of the Cancellation Window will result in a $50.00 cancellation fee.

If you cancel outside of the Cancellation Window, or you do not come to your appointment ("no-shows"), you will be charged a $50.00 cancellation fee, which you must pay immediately and prior to resuming any treatment. If or you are more than 15 minutes late to your appointment your therapist reserves the right to cancel your appointment. Your insurance company will not reimburse you for late cancellation fees.

We've found that regular appointment attendance is a crucial part of treatment success. For these reasons, upon three consecutive missed appointments, two no-shows, or chronic inconsistent attendance, we may cease further treatment of you, notify your physician, and document such in your medical record. If you are discharged for lack of attendance, you will need a new physician referral to resume treatment with Vitality.

I acknowledge and agree to this policy. _____ *(initial)*

Indemnification & Assumption of Risk

Although we endeavor to provide you with skilled and attentive care, as a condition of receiving physical therapy services from Vitality and to the greatest extent permitted by law, you agree to indemnify us against all claims, liabilities, losses, damages, suits, costs, and expenses (including reasonable attorney's fees) relating to our physical therapy services to you. You agree to assume all risk of property damage, injury, or death associated with any physical therapy provided to you.

We will discuss the anticipated risks and benefits of, and alternatives to, your planned treatment, and you will have an opportunity to ask questions. The terms of this indemnification and assumption of risk policy shall survive the expiration date of any treatment.

I acknowledge and agree to this policy. _____ *(initial)*

Medical Records Request Policy

We maintain records about your treatment at Vitality. To obtain a copy of your records, please submit a written request on the form that we provide, including your full name, date of birth, date of request, and signature. Please also specify to whom you want your records sent, their address, and the reason for your request. Please note that in some instances we may charge a reasonable and cost-based copying, postage, shipping, scanning, or digital storage device fees.

I acknowledge and agree to this policy. _____ *(initial)*

Acknowledgement & Agreement

I, the undersigned, hereby acknowledge and agree that:

- I have read and understand these Physical Therapy Services Policies & Procedures, and I have truthfully and to the best of my knowledge provided the information requested;
- I am bound by these Physical Therapy Services Policies & Procedures;
- I have been offered a copy of Vitality's Notice of Privacy Practices;
- I authorize the use of my health information as provided herein;
- I verify that I am not covered by a Medicare or Medicaid policy;
- I shall indemnify Vitality and its providers; and
- I voluntarily assume all risks of treatment.

My Name: _____ **Signature:** _____ **Date:** _____

If you are a minor (under 18 years old), please ask your parent or guardian to review this document and sign below.

I, the undersigned, am the parent or guardian of the above referenced patient. I have reviewed this document and agree to be bound by it on my behalf and on behalf of the patient.

My Name: _____ **Signature:** _____ **Date:** _____

------- For Vitality's use only: -------

Initials of reviewing provider: _____ *Date of review:* _____

Did the patient have questions about these Physical Therapy Services Policies & Procedures?

Yes ☐ *No* ☐ *If yes, briefly note those questions:* _____

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