Peregrine PT
PHYSICAL THERAPY

Core and Pelvic Floor Exercise Informed Consent

Name _____ Date of Birth _____ / _____ / _____

Phone Number_____ Email Address _____

Emergency Contact _____ Phone _____

A) I understand and am aware that strength and flexibility exercises associated with Core and Pelvic Floor/Physical Therapy can be potentially hazardous activity. I do hereby assume all responsibility for my participation in the activities, facilities, programs and services offered at or by instructors of *Peregrine Physical Therapy* and for my utilization of any and all equipment in connection with these activities, facilities, programs and services.

B) I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would limit my participation. I acknowledge that I have either had a physical examination and been given my physician's permission to participate, or that I have decided to participate in the activity without the approval of my physician and do hereby assume all responsibility for my participation and activities.

C) I further agree that my participation in any and all activities, facilities, programs and services provided at or by instructors of *Peregrine Physical Therapy* is at my own risk and that I assume any and all risk of injury, illness, damage or loss that might result. I also agree to assume all risk of damage, loss or theft to or of any of my personal property.

Please write a "√" for current and write and "H" for history of the following:

	Pregnancy (_____ years ago)		Inguinal/Umbilical Hernia		Hip or Knee Pain or Surgery
	Cancer (type:)		Pelvic or Perineal Pain		Ankle or Foot Pain or Surgery
	C-Section (_____ years ago)		Stress/Urge Incontinence		Shoulder or Elbow Pain or Surgery
	Osteoporosis/Osteopenia		Back, SI, or Coccyx Pain		Wrist or Hand Pain or Surgery
	Endometriosis, PCOS, Fibroids		Neck Pain		TMJ or Face Pain
	DRA/Diastasis Rectus Abdominis		Mid Back or Rib Pain		Fibromyalgia
	Prolapse, Cystocele, Rectocele		Radiculopathy/Pinched Nerve		IBS, UC, Diverticulitis

Please explain any other condition or surgery, which may limit you from performing the exercises:

_____

_____

What goals do you have for your Core and Pelvic Floor practice?

_____

I agree to the bound by the reasonable rules and regulations set forth by the instructor &/or physical therapist for safe participation in Core & Pelvic Floor exercise, and that the foregoing obligations shall be binding of me personally, as well as upon my family and my heirs, executors, administrators, and assigns.

Participant Signature _____ **Date**_____

Legal Guardian Signature _____ **Date**_____

Peregrine PT
PHYSICAL THERAPY

Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email or texting communication.
- ☐ I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail
- ☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail

E-mail address: _____

Phone number: _____

Patient Signature: _____ Date_____

Parent/Guardian Signature: _____ Date_____

Payment Agreement and HIPAA Acknowledgement

Thank you for choosing Peregrine Physical Therapy, Inc. as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at the time of service unless you make other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- Patients are responsible for the copy charges for full medical records when requested from patients, insurance companies, and other doctor's offices. Copy charges are $25.00 for small records and $50.00 for large records.
- **Cancellation Policy**. If an appointment cannot be kept, or less than 24 hours notice is given, there is a $50 charge.
- **Repeated Missed Appointment Policy.** If a patient misses 3 appointments, Peregrine Physical Therapy reserves the right to cancel all future appointments.
- **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and many of the services we offer are not covered by Medicare. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.
    - **Medicare Advantage Plans and Medicare Replacement Plans.** We are not in-network with any Medicare Advantage or Replacement Plans. If your Medicare Advantage or Replacement Plan offers out-of-network benefits for services received from providers not enrolled with Medicare and we don't have to directly submit your claims, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers.

However, you should be prepared that your health plan may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your health plan to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

- **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.

- **Wellness & Fitness Services.** Most commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other visits.
  - **Use of Health Savings Accounts (HSA).** If you purchase a pre-paid package plan through your HSA account we will give you a receipt for the pre-paid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.
  - **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.
- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **Late Payment Penalty.** Unless prohibited by applicable law, a late payment penalty in the amount of 0.5% per month (6% per year) may be added to your bill for any and all claims that are not paid within thirty (30) days of the invoice or statement date. You agree to be personally responsible for paying this late payment penalty.

- **Collection Policy.** You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.
- **Service Termination Policy.** If we determine at any time that conditions in your home create a potentially unsafe environment for our providers, we may, at our sole discretion, terminate our services with you. If we do so, we will make reasonable efforts to refer you to the services you need to resolve the issue that is causing a potentially unsafe environment. If you have prepaid for any services, we will refund any monies paid for services not yet received as of the date or our termination.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Peregrine Physical Therapy, Inc. and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Peregrine Physical Therapy, Inc. and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Signature of Provider Representative

HIPAA Acknowledgement

Please read the Notice of Privacy Practices posted on the website for Peregrine Physical Therapy and sign the acknowledgement below.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of Peregrine Physical Therapy Notice of Privacy Practices.

X_____Date:_____

Signature of Patient and/or Guardian

A photocopy of this agreement is to be considered valid, the same as if it was the original.