WONSETTLER
Physical Therapy & Specialized Health

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100 Wonsettler Road
Scenery Hill, PA 15360

_____ (Initials) **CONSENT TO TREATMENT:** I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

_____ (Initials) **PATIENT INFORMATION CONSENT FORM (HIPAA):** I understand that Wonsettler Physical Therapy and Specialized Health (WPT) may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that WPT will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes as noted in WPT's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point WPT has 30 days to respond to my request.

_____ (Initials) **AUTHORIZATION FOR GYM USE:** As part of my care at WPT, I may have access to the gym to further my experience and progress. I participate in the activity at my sole risk and responsibility. I assume all risk and responsibility for any injury or property damage resulting from my participation in the activity. The activity is not considered a work-related function. Injury, medical treatment, or loss of work time required from an injury due to participation is the sole responsibility of the participant. I release, indemnify, and hold harmless WPT and its employees, physical therapists and trainers from and against any actions or claims which may be made by me or on my behalf in respect of, or arising out of any injury, loss, or damage caused to me or my property whether by my negligence or in any way whatsoever.

_____ (Initials) **FINANCIAL RESPONSIBILITY:** I agree to pay my rehabilitation therapy provider ("Provider") all amounts that are due and owing for services rendered by Provider which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney's fees.

_____ (Initials) **AUTHORIZATION TO USE RECORDING DEVICES:** In conjunction with my care, I authorize the use of recording devices, including, without limitation, a camera and/or mobile device to record videos and/or images for the purposes of enhancing my care. In addition, I authorize the transmission of such recording device videos and/or images to my rehabilitation provider and/or the treating physician through secure email and/or text message. I acknowledge that such videos and/or images will only be used or disclosed for treatment purposes, and that my rehabilitation provider will not further use or disclose such videos and/or images for any other purpose without my written authorization.

Signature of Client/Legal Guardian:_____ Date: ____/____/____

ATTENDANCE POLICY:

Wonsettler Physical Therapy and Specialized Health strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- If you are more than 30 minutes late for your appointment and fail to notify us, treatment may be canceled and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELED AT LEAST 24 HOURS IN ADVANCE or a fee will be charged for that appointment.
- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- At week's end, ALL PATIENTS, regardless of insurance/third party payor, will be charged a **$50** CANCELLATION FEE for each late, late-canceled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.
- No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor. Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.
- Failure to pay any outstanding balances resulting from cancellations and/or no show fees will result in denial of treatment upon arrival until the debt has been paid in full.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

All of the staff at **Wonsettler Physical Therapy and Specialized Health** appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

ATTENDANCE POLICY: I acknowledge that I read and understand the Attendance Policy and agree to abide by its terms and conditions.

Signature of Client/Legal Guardian:_____ Date: ____/____/____