POLICIES AND INFORMED CONSENT FOR PHYSICAL THERAPY

Telan Nelson, PT
CA PT License #38927

PRIVACY RIGHTS

You have reviewed a copy of and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of your health information. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA). You understand that Telan Nelson, PT has a right to change the Notice of Privacy Practices from time to time. You may request the most current Notice of Privacy Practices at any time.

____ __________
Client/Client Representative/Guardian Signature Date

CANCELLATION POLICY

As a courtesy to other clients trying to schedule, a minimum of 24-hour advance notice for cancellations is required to avoid a late cancellation fee. Emergencies or illness are excusable.

A $40 fee for cancellation of a 60-minute session or a $20 fee for the cancellation of a 30-minute session will be collected prior to conducting future sessions.

DIRECT ACCESS

Direct Physical Therapy Treatment Services Disclosure Statement:

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California.
Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

__________________________ ___________________________ _______________
Patient's Signature Printed Name Date

(Your signature acknowledges that you have been informed of the CA direct access law for physical therapy. If you have a referral for physical therapy, physical therapy services will be provided per your referral guidelines.)

FINANCIAL AND INSURANCE RESPONSIBILITY POLICY

Non-Medicare Physical Therapy Clients:
Telan Nelson, PT is not a preferred provider for insurance companies, with the exception of Medicare. Instead, Telan Nelson, PT provides physical therapy on a **"fee at time of service"** basis. By disengaging from a contracted status with insurance companies, Telan Nelson, PT does not have to limit the time or quality of treatment provided because of insurance company restrictions or elevate fees due to the financial burden to pay for billing services.

Fees:
Initial Evaluation (1 hour): $130
Follow-up Sessions (1 hour): $110
*Shorter sessions available on an as needed basis and must be pre-arranged with Telan.

Statements:

- I have reviewed the clinic fees, insurance and financial policies. I understand that **I am responsible for payment at the time of services**, regardless of any other applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which I am involved.
- I understand that it is my responsibility to call my insurance company ahead of time, obtain any pre-authorization that is necessary, and get an estimate of my benefits for **non-preferred provider** physical therapy services provided by Telan Nelson, PT.
- I understand that I may request a receipt (Superbill) from my therapist, and that it is my responsibility to submit to my insurance company for possible reimbursement, if desired. Telan Nelson, PT does not guarantee reimbursement by your insurance company.
- Forms of payment include: cash, check, debit, or credit (including HSA or FSA accounts as applicable).

By signing, you agree to the financial and insurance policies and statements above:

____ ______________
Client/Client Representative/Guardian Signature Date

STATEMENT OF INFORMED CONSENT TO PHYSICAL THERAPY TREATMENT AND EXERCISE INTERVENTIONS

I understand and am informed that Telan Nelson, PT performs hands-on manual therapy Physical Therapy care in addition to Pilates, Wellness, and Sport-specific exercise training.

I understand that I am expected to cooperate to the best of my ability with the evaluation and treatment program.

I understand that some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern; if it does not subside in 24 hours, I agree to contact Telan Nelson, PT.

I understand that I will be able to stop treatment if I feel any discomfort or pain. I will never be forced to perform any procedure or exercise that I do not wish to perform.

I understand that should I feel uncomfortable or embarrassed, I may refuse the procedure, stop the procedure, and/or request to terminate physical therapy services. Because of the nature of physical therapy services provided, I may be asked to disrobe. If this is necessary, my privacy, modesty and dignity will be considered at all times by my physical therapist.

I understand that there are no promises or guarantees regarding a cure for or improvement in my condition. The number of treatments/sessions needed and recovery time can vary widely due to the age of the injury, number of times injured, age of the client, and many other contributing factors.

By signing below, I voluntarily authorize Telan Nelson, PT to use interventions as deemed necessary for my safe and effective recovery. This consent is intended as a waiver of liability for such treatment. I understand that I may choose to discontinue treatment at any time and for any reason.

I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) or training for which I seek intervention from Telan Nelson, PT.

Printed Client Name ____ **Date**__________________

Client/Client Representative/Guardian Signature ____