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

Medicare Physical Therapy Clients:
Telan Nelson, PT is a participating provider with Medicare. As of January 1st of each calendar year there is a **maximum benefit of $2,110 per Medicare beneficiary**. This cap is figured both on physical therapy and speech therapy services combined. There are exceptions to the cap on a case-specific basis.

Please inform Telan Nelson, PT if you have already received physical therapy or speech therapy at any other facilities or through home health services during this current calendar year in order to best monitor your account balance.

Telan Nelson, PT will do the best to maintain a running account balance and will notify you when the balance is approaching the maximum allowable. Patients are responsible for monitoring account balance, so as not to exceed the maximum cap and be held responsible for outstanding charges.

It will be the patient's decision to continue physical therapy care beyond the benefit cap, at which time they will be financially responsible for services.

Patients are financially responsible for any annual deductible and/or applicable co-insurance according to their Medicare and secondary insurance contracts.

Clinic Fees:
Physical Therapy services are billed in "units" which are 15-minute increments. Most sessions will be 4 units per 1-hour session. Telan Nelson, PT's current fee schedule is based on the physician fee schedule set by Medicare.

Statements:

- I have reviewed the above clinic fees, insurance and financial policies. I understand that **I am responsible for payment at the time of service** for any annual deductible and/or applicable co-insurance according to my Medicare and secondary insurance contracts.
- I understand that it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization that is necessary for physical therapy services provided by Telan Nelson, PT.

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 _____