Texas Back Institute®

Consent for Treatment

CONSENT FOR TREATMENT

During the course of my treatment at the Texas Back Institute (TBI) I,_____, understand, consent and agree that I will be seen, evaluated and treated by qualified healthcare professionals. Because TBI is an advanced learning environment, I may be seen by any of TBI's associates. I understand that these associates are fully trained and qualified. I further understand that I may, at any time, refuse evaluation and treatment by the associates without fear of retribution or jeopardy of any healthcare provided to me.

_____ _____

Signature Date

_____ _____

Witness Signature Date

If the patient is a minor or under legal guardianship:
By my signature as a guardian, I authorize evaluation and medically necessary treatments.

_____ _____

Signature of parent or legally responsible guardian Date

04/10/19

Texas Back Institute®

Insurance Authorization

Physical Therapy Financial Policy

INSURANCE AUTHORIZATION

I authorize Texas Back Institute to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I assign all medical and surgical benefits to include major medical benefits to which I am entitled, to the Texas Back Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

PHYSICAL THERAPY FINANCIAL POLICY

Insurance plans sometimes have limits and/or maximum allowed charges on Physical Therapy treatment and services. There may be limits on the number of visits or type of care your insurance company will cover per year and/ or per injury. **Know your plan benefits. You are responsible for payment regardless of your insurance benefits.** If your plan does have limits or maximums, you will be expected to pay at the time of service when you reach these limits. You need to be aware if you have had any previous physical therapy or chiropractic treatments as insurance companies sometimes consider these as the same type of care and will count towards the total visits for benefits. If you have any questions regarding your coverage for physical therapy, please call your insurance company for clarification.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF MY INSURANCE BENEFITS.

Please sign that you have read and agree with the above Authorization and Financial Policy.

_____ _____

Signature Date

_____ _____

Witness Signature Date

04/10/19

Plano Office: 6020 W Parker Road ■ Suite 200 ■ Plano, TX ■ 75093-7916 ■ 972-608-5011 ■ 972-608-5029 Fax

Texas Back Institute®

Acknowledgement Form

NOTICE OF PRIVACY RIGHTS ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Rights, which I have reviewed, and give my permission to Texas Back Institute to use and disclose my health information in accordance with it.

Please sign that you have read and agree with the above Consent for Treatment and Acknowledgement.

_____ _____

Name of Patient Signature of Patient

_____ _____

Date Signature of Parent or Guardian

I give permission to Texas Back Institute to release medical information to the following person(s): (please print names below)

_____

_____

_____

This Authorization will expire in two (2) years from the above date unless written revocation is received.

04.10.19

Texas Back Institute®

Cancellation Policy

The Physical Therapy department has a **cancellation policy**. This policy is designed to encourage patients to honor their appointments and allow us adequate time to fill any vacancies with patients desiring that appointment time.

We require a 24 business hour notice for cancellation of any scheduled appointments. Failure to provide notice will result with the following fees to be charged to your account:

Evaluation- $50.00 Fee

Follow up Visit- $25.00 Fee

Note: A patient showing up 15 minutes or later to their scheduled time without calling or communicating will be considered a NO SHOW and be subject to the above fees. The exception would be if the patient can be reasonably worked into the schedule at the time of their late arrival.

We thank you in advance for your understanding and compliance to help us give all our patients the best care possible.

Signed_____ Date_____

Witness_____ Date_____

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