BENTZ PHYSICAL THERAPY
PATIENT POLICY / H.I.P.A.A. CONSENT

Rev. 10/19

Thank you for choosing Bentz Physical Therapy for your rehabilitation needs. We are committed to providing you with the best possible care. In order to achieve the goals we have set with you, we need your assistance and acknowledgment of our policies / consents. Please follow these guidelines as you complete the required paperwork.

PATIENT POLICY:

1) If you are under the age of 18, we require that a parent or legal guardian sign the paperwork. Responsibility for treatment of minor children rests with the person seeking treatment and whoever signs the paperwork.
2) If your insurance requires preauthorization and/or a referral for physical therapy, it is your responsibility to ensure that the referring physician or your PCP has obtained the necessary preauthorization. If we do not have the proper authorizations or referral at the time of your visit, it may be necessary to reschedule your appointment, or you will be required to pay for your visit in full. In the event that we are paid for the service by your insurance company, you will be reimbursed for the visit, less any applicable copay or deductible.
3) **If you are late for your appointment by more than 10 minutes, we will require you to reschedule, or wait for the next available opening.**
4) **If you wish to change or cancel your appointment, we require a minimum 24 hour notice. Anything less will result in a $20 fee charged to your account.**
5) We will verify your insurance benefits as a courtesy to you, based on the information that you provide to us. We will notify you prior to treatment of your insurance benefits and your financial responsibility. The benefits that we receive from your insurance company may not be accurate. We encourage you to find out and know what your insurance company pays for outpatient physical therapy in an office setting.
6) Co-payments, deductibles, supplies and DME (Durable Medical Equipment) charges will be collected at the time of service. We accept cash, check, MasterCard, Visa, Discover and American Express. There will be a $25 charge for any returned checks.
7) Failure to abide by this policy or if we do not receive payment within 60 days will result in our taking the necessary action to collect payment.

H.I.P.A.A. CONSENT:

Authorization of Use and Disclosure of Protected Health Information (PHI)

I understand that, under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (H.I.P.A.A.), I have certain rights to privacy regarding my protected health information (PHI). PHI may originate in your medical record at Bentz Physical Therapy, or may be received from outside health entities and filed in your medical record.

I understand that this information can and will be used by Bentz Physical Therapy, to: (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, (b) Obtain payment from third-party payers, (c) Any such other purposes permitted under H.I.P.A.A.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Bentz Physical Therapy has the right to change its Notice of Privacy Practices from time to time, and that I may obtain a current copy of the Notice of Privacy Practices by contacting the Privacy Officer at 800 Hemphill Fort Worth, TX 76104.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Bentz Physical Therapy is not required to agree to my requested restrictions, but if Bentz Physical Therapy does agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Bentz Physical Therapy may have taken action relying on this consent.

Designation of Those Who Can Receive Information About My Care

I understand that designated individuals have access to information about me that is created by or on behalf of Bentz Physical Therapy, and that this information can include PHI. I understand that I may revoke this designation at any time by completing a new form, and that this designation will not expire until I actively revoke it. I understand that these individuals will not be able to request a paper or electronic copy of my health records without having completed an Authorization to Release Medical Information form.

I understand that my healthcare treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not designating an individual below.

I understand that this designation does NOT allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions, HIV/AIDS status, abortion, or sexually transmitted disease, if any.

We look forward to having you as a patient and appreciate your consideration in following our patient policy.