JAG-ONE PHYSICAL THERAPY

PATIENT FINANCIAL RESPONSIBILITY

JAG-ONE Physical Therapy's focus is your overall health and wellness. As we continue to strive to help you meet these standards, it is important to us that you understand the terms "**Medically Necessary**", "**Clinically Appropriate**", "**Benefit Maximum Met**" and how this relates to your treatment.

"**Medically Necessary**" is defined as treatment or services that are specific to your diagnosis. When treatment is deemed medically necessary, your insurance company will reimburse JAG-ONE PT for services rendered according to physical therapy care that has a direct connection to document improved function based on our contractual agreement.

"**Clinically Appropriate**" or "**Benefit Maximum**": Insurance companies may deny care despite treatment that continues to manage, reduce or eliminate your pain. This may be "clinically appropriate" for your circumstances but may not be considered "medically necessary" by your insurance carrier. Benefit Maximum is defined as a specific number of physical therapy visits allowed by your insurance policy during a specific time frame. Most treatments reach a point where no further improvement can be expected. This is called the point of maximum therapeutic benefit (MTB). MTB can be reached when complaints either fully resolve, or when pain and/or disability persist – even with ongoing treatment.

"**Denials/Appeals**": It is a patient's responsibility to initiate an appeal with the insurance provider when services are denied.

JAG-ONE Physical Therapy will provide the necessary clinical information upon request.

If your insurance company determines that services are no longer medically necessary, you will be billed $100.00 per visit for services that have been rendered.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that JAG-ONE Physical Therapy may verify such coverage as a courtesy to me. JAG-ONE PT will not be held responsible or liable for inaccurate information or denials provided by your insurance carrier after services have been rendered.

My signature below acknowledges that I have read and fully understand that:

1. JAG-ONE Physical Therapy has discussed medical necessity limitations, clinically appropriate care, and specific number of office visits allowed per my insurance company.
2. I have been informed of my financial responsibility if my insurance company denies all or part of these services as not medically necessary.
3. I fully accept the financial responsibility to pay for denied services at the time my insurance carrier deems my treatment not medically necessary.
4. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier.

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

JAG-ONE PHYSICAL THERAPY

CONSENTS AND DISCLOSURES

(I) CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS

Ordinarily, discussion of medical records or billing information would not be disclosed to anyone but yourself over the phone. However, with your consent, our staff will speak with your significant other, close family member or other designated individual. Please understand that you are waiving your right to confidentiality if this consent is given.

_____ INITIAL HERE TO GIVE CONSENT

I am hereby giving my consent to JAG-ONE Physical Therapy office staff to discuss my medical condition or billing concerns with the person/persons I have designated below.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

(II) CONSENT TO RELEASE INFORMATION TO A TELEPHONE ANSWERING MACHINE

In an effort to protect your confidentiality, medical history and appointment reminder specifics (including date & time) will not be left on your answering machine, email and/or received in a text message; however, if you prefer us to do this, we can with your consent. Please understand that you are waiving your right of confidentiality if you give your permission.

_____ INITIAL HERE TO GIVE CONSENT

I am hereby giving my consent for the JAG-ONE Physical Therapy office staff to leave medical history or appointment reminders (including date & time) on my telephone answering machine, email and/or text message.

_____ INITIAL HERE TO DECLINE CONSENT

(III) PATIENT AUTHORIZATION TO TREAT AND SUBMIT MEDICAL CLAIMS

I authorize payment to JAG-ONE Physical Therapy, LLC for all physical therapy services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I consent to be assessed by and to receive treatment from JAG-ONE Physical Therapy, LLC consistent with a plan of care. I confirm that I have been informed and have participated in planning the care and procedure(s) to be carried out by JAG-ONE Physical Therapy LLC and sign this consent willingly and voluntarily.

I consent to the release of information and/ or disclosure to JAG-ONE Physical Therapy, LLC of all or any part of my medical record to other health care providers involved in my care or third-party payers as is necessary for processing claims.

I am aware my child is receiving Physical/Occupational Therapy at JAG-ONE Physical Therapy. I am unable to attend his/her office visits. Please accept this form as my consent to treat my child.

PARENT/ GUARDIAN INITIALS IF APPLICABLE: _____

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENTS AND DISCLOSURES.

PATIENT SIGNATURE: _____ DATE: _____

PARENTAL SIGNATURE FOR MINOR: _____ DATE: _____

JAG-ONE PHYSICAL THERAPY

PATIENT BILL OF RIGHTS

JAG-ONE Physical Therapy strives to ensure that each patient is provided the highest quality of care in accordance with high professional standards that are continually maintained and reviewed. We understand that patients have entrusted their care to us and we treat all patients with dignity, respect, and only provide appropriate services as needed. By requiring informed consent for treatment, we assure that each patient and/or his/her representative is involved in aspects of a treatment plan. Patients and their representatives are afforded consideration of their privacy concerning their own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discretely. The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. We will endeavor to involve patients in their treatment program by incorporating their feeling, interest, attitudes and goals in the treatment planning and implementation process. A patient has the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual preference or national origin.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE PATIENT BILL OF RIGHTS.

PATIENT SIGNATURE: _____ DATE: _____

PARENTAL SIGNATURE FOR MINOR: _____ DATE: _____