TERRIO
Physical Therapy & Fitness
Get Informed. Get Moving. **Get Better!**

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by TERRIO Physical Therapy-Fitness, Inc. for the purposes of evaluating or providing treatment to me, obtaining payment for my health care bill or conducting health care operations of TERRIO Physical Therapy-Fitness, Inc.. I understand that evaluation or treatment of me by TERRIO Physical Therapy-Fitness Inc. may be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this consent, in writing, at any time, except to the extent that TERRIO Physical Therapy-Fitness, Inc. has taken action in reliance on this consent.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. TERRIO Physical Therapy-Fitness, Inc. is not required to agree to the restrictions that I may request. However, if TERRIO Physical Therapy-Fitness, Inc. agrees to a restriction that I request, the restriction is binding on TERRIO Physical Therapy-Fitness, Inc.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review TERRIO Physical Therapy-Fitness, Inc. HIPAA Notice of Privacy Practices prior to signing this document. The TERRIO Physical Therapy-Fitness, Inc. HIPAA Notice of Privacy Practices has been provided to me. The HIPAA Notice of Privacy Policies describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the TERRIO Physical Therapy-Fitness, Inc.. The HIPAA Notice of Privacy Practices for TERRIO Physical Therapy-Fitness, Inc. is also provided at the front desk and on the TERRIO Physical Therapy-Fitness, Inc. website at www.myTERRIO.com . This HIPAA Notice of Privacy Policies also describes my rights and TERRIO Physical Therapy-Fitness, Inc. duties with respect to my protected health information. TERRIO Physical Therapy-Fitness, Inc. reserves the right to alter the TERRIO Physical Therapy-Fitness, Inc. HIPAA privacy practices in order to reflect any changes to the federal HIPPA policies. I may obtain a copy of Privacy Practices by accessing the TERRIO Physical Therapy-Fitness, Inc. website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient/Guardian Initials: _____

Release of Information

The undersigned authorizes TERRIO Physical Therapy-Fitness Inc. whether signing as patient or guardian, to release medical information as requested by insurance companies, employers, and other responsible parties, unless otherwise directed. If authorization to release information is denied, payment for services rendered will be due at time of services.

Patient/Guardian Initials: _____

Assignment of Insurance Benefits

The undersigned agrees, whether signing as patient or guardian, direct payment to TERRIO Physical Therapy-Fitness, Inc. of any insurance benefits otherwise payable to or on behalf of the undersigned for evaluation and treatment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. I understand that any co-pay or share or cost will be charged and I am responsible for payment of any such charge that may be due. I understand that a $28.00 late fee will be charged to my account if I do not pay my balance off in full within 60 days of the balance being transferred from my insurance to myself. All co-pays are due at the time of service. I also authorize TERRIO Physical Therapy-Fitness to deposit checks received on my account when made out to me.

Patient/Guardian Initials: _____

Cancellation/No Show Policy

All families must call 12 hours prior to scheduled appointment to cancel to avoid getting charged a $50.00 Cancellation/No Show Fee. All missed appointments are documented in your child's chart. Due to the number of children needing therapy and our limited availability at TERRIOKids, if your child misses 3 appointments in a row or 4 out of 6 appointments, he/she will be removed from the schedule. We understand there will be extenuation circumstances at times and believe this allows for some flexibility. If no effort has been made to reschedule, TERRIO Physical Therapy-Fitness, Inc. will attempt to contact the Parent/Guardian. After the third failed attempt to schedule the patient, the therapist will contact the referring physician and advise discharge from therapy due to non-compliance by the patient. This policy helps insure the treatment necessary for fast recovery and we appreciate your cooperation with this policy.

Patient/Guardian Initials: _____

Authorization for Detailed Messages:

I give consent to TERRIO Physical Therapy-Fitness, Inc. to leave detailed information with an individual or on an answering machine regarding treatment, appointment confirmation, billing information, or other related information. Unless notified in writing, this consent will remain in effect permanently.

Please print below all numbers which TERRIO is allowed to leave detailed information:

1. Home: _____
2. Cell: _____
3. Work/Alternate: _____

Patient/Guardian Initials _____

Patient/Guardian Authorization for Treatment

I herby authorize TERRIO Physical Therapy-Fitness, Inc. to take/use photo images of me (my child if signed by parent of minor) during any/all aspects of my/my child's treatment and utilize such images for the purpose of marketing; including but not limited to television, print, internet, Facebook, etc.

Patient/Guardian Initials _____

Patient Name (Print): _____ Patient DOB: _____

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____