WINGARD
Wellness & Therapy Services

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed Physical Therapist employed by Wingard Wellness & Therapy Services LLC (WWTS). The Physical Therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

[ ] Fee for Service (Charges)

Physical Therapy Initial Evaluation: $150.00

Physical Therapy Treatment Visit: $100.00 (PT treatment sessions last between 45-60 minutes)

Additional Supply charges may apply.

[ ] Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to WWTS for services rendered. WWTS will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Patient Information Consent Form (HIPAA)

I have read and fully understand WWTS Notice of Information Privacy Practices. I understand that WWTS may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that WWTS will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes as noted in WWTS Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point WWTS has 30 days to respond to my request.

Release of Information: I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

Patient Signature _____ Date_____