

# Omaha Sports Physical Therapy, PC

## Informed Consent

**Authorization for Medical Treatment:** I authorize the physical therapist(s) in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes, but is not limited to, routine diagnostic procedures, the use of physical modalities, and the prescription of therapeutic exercise. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician or physical therapist whose care the patient is under.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment in Omaha Sports Physical Therapy, PC. I acknowledge that my care is under the direction of my treating physician(s) and Omaha Sports Physical Therapy, PC will follow the instructions of my physician(s) in the provision of said care.

**Assignment of Facility Benefits:** I/we assign all benefits to Omaha Sports Physical Therapy, PC, and authorize direct payment to Omaha Sports Physical Therapy, PC, address, all insurance benefits or Medicare/Medicaid benefits to which I/we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I/we agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

**Statement of Responsibility:** I understand that I am financially responsible to Omaha Sports Physical Therapy, PC as the patient, parent, guardian, conservator, or insured for all charges not covered by the above assignment, which charges may include any medical insurance deductibles, co-pays, and/or co-insurance. I understand that to sign as a Guarantor means that if the patient does not pay Omaha Sports Physical Therapy, PC for all charges due, I, as Guarantor, will be responsible for such payment. I further understand that payment is due 30 days after receiving the billing statement; if there has been no payment toward my account in excess of 60 days, I may be levied interest and/or late fees at the current rate allowed by law.

**Non-covered Medicare/Medicaid Services:** Medicare/Medicaid have certain outpatient procedures that are excluded from coverage, including but not limited to those of routine diagnostic workups or routine physical examinations. If the patient's medical chart indicates that the patient's treatment is one for which no Medicare/Medicaid benefits are allowable, I understand that all charges incurred during treatment will be the patient's own financial responsibility. There are other limitations and charges for which the patient may be responsible; the patient will be provided additional information with regard to these charges and limitations on a separate written form.

**Authorization to Release Information to Insurance Company/Third Party Payor:** I authorize Omaha Sports Physical Therapy, PC and any physical therapist, practitioner, or other person, any hospital including Veteran's Administration or governmental hospital any medical service organization, any insurance company, or any other institution or organization to release any medical information about the patient necessary to determine any benefits which may be payable for this treatment.

**Authorization for Quality Review:** I acknowledge that it may be appropriate for Omaha Sports Physical Therapy, PC to review the overall care provided to patients prior to and following the patient's treatment. I understand that this review is for the sole purpose of maintaining and improving the overall quality of healthcare provided to Omaha Sports Physical Therapy, PC patients. Therefore, I authorize the physical therapists who cared for the patient at Omaha Sports Physical Therapy, PC to provide Omaha Sports Physical Therapy, PC with copies of records regarding my care that pertain to the treating diagnosis as needed for quality review purposes. This consent is valid for the care provided to me for up to 12 months before and no longer than three months after my treatment at Omaha Sports Physical Therapy, PC.

**Personal Valuables:** Omaha Sports Physical Therapy, PC shall not be liable for the loss of or damage to any personal property.

The undersigned certifies that he or she has read the foregoing or is the parent or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

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| Patient's Signature/Parent if Minor/Power of Attorney            | Date                                   |
| Responsible Party's Signature (if not same as patient or parent) | Insured's Signature                    |
| Witness to Signatures  | Patient Unable to Sign Consent Because |