PATIENT CONSENT FORM

Please read and sign below if agreeing that all information provided herein is true and correct:

Consent to Treatment: I consent to physical therapy treatment at CORE 3 Physical Therapy LLC (CORE 3 PT) under the prescription of my referring physician or my physical therapist via direct access.

Information Release: I give permission to CORE 3 PT to release information, verbal and written, contained in my medical record and other related information to my physician, insurance company, rehabilitation nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons.

Privacy of Information: I acknowledge that CORE 3 PT has made available a copy of their HIPAA Privacy Policy, located in the waiting area of the clinic. A copy may be obtained for my records by request. Information without patient identifiers may only be used for quality assurance and/or outcomes purposes (i.e. research).

Payment Responsibility: I expressly guarantee full payment of this account for all services rendered by CORE 3 PT. Regardless of my quoted insurance benefits, I understand that I am fully responsible for all charges incurred. CORE 3 PT will file all claims to my insurance carrier and my insurance carrier will either: 1) reimburse CORE 3 PT directly if they are in-network with my insurance plan, or 2) reimburse me for these services and I am then responsible to remit payment in full to CORE 3 PT. If I have insurance benefits for physical therapy, I am expected to remit payment for my quoted deductible balance, coinsurance, and/or copayment. If I do not have insurance coverage, I understand that the payment is due in full to CORE 3 PT at the time of service.

Medicare Patients: I have been informed that Medicare applies a combined 2023 annual limitation for physical therapy and speech language pathology services of $2,150. I understand that I am responsible for my 2022 annual deductible of $226, any remaining balance after Medicare and my supplement have paid, and 100% of the charges if I exceed the $2,150 annual limitation. I have also been informed that Medicare does not allow for any overlap of outpatient physical therapy with home health care and/or services provided at a skilled nursing facility. It is my responsibility to confirm my home health discharge date. I am responsible for all charges denied by Medicare that overlap with home health care.

Auto Insurance Patients: CORE 3 PT will bill all claims to either my confirmed auto carrier and/or my health insurance for charges related to an auto accident. It is my responsibility to inform CORE 3 PT if my auto insurance medical benefits have been exhausted at any time during my course of treatment with CORE 3 PT. My auto insurance carrier will not inform CORE 3 PT when I reach or exceed the medical benefit. I am required to provide a copy of the letter to CORE 3 PT that I will receive at home stating my benefits have been exhausted. I am responsible for all unpaid balances, including all deductible, coinsurance or copayments at the time of service.

Cancellation Policy: I understand CORE 3 reserves the right to reschedule my appointment if I am more than 15 minutes late. I acknowledge that appointment times are valuable and by giving last minute notice I prevent someone else from being able to schedule that time slot.
I understand that CORE 3 reserves the right to charge a $50 fee if I fail to cancel an appointment with at least 24 hours notice or fail to show up for my appointment.

_____ _____
PRINT Patient Name Date

_____
SIGNATURE OF Patient or Guardian

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PATIENT DEMOGRAPHICS

Please fill out each line as applicable

Patient Name: _____ Pronouns: _____

Date of Birth:_____Occupation:_____

Age: _____ Height: _____ Weight: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home): _____ Phone # (cell): _____

*Which number(s) is our staff authorized to leave phone messages? Home: _____ Cell: _____

Email: _____

How did you hear about us?

- ❑ Physician
- ❑ Friend/Family
- ❑ Website
- ❑ BNI Referral
- ❑ Other_____
- ❑ Live Talk
- ❑ Facebook
- ❑ Instagram
- ❑ Google Search

Referring Healthcare Provider: _____

Primary Healthcare Provider: _____

OBGYN (For women): _____

Emergency Contact: _____

Relationship: _____Phone #: _____

☐ Check the box to the left to allow the above contact to receive your medical information from CORE 3.

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