LAFAYETTE PHYSICAL THERAPY, INC.

Patient Information

Legal Last Name		Legal First Name	MI	Sex	Preferred Name
Home Phone	Cell Phone	SSN	DOB		Marital Status
Address		City	State		Zip
Employer		Occupation	Work Phone		
Person responsible for payment		Relation	Phone		
Emergency Contact Person*		Relation	Phone		*For emergencies and urgent info if we are unable to get ahold of you.
Have you received any outpatient rehabilitation therapy this year? ☐ Yes: _____ # visits ☐ No					
Automated Appt. Reminders: Please select a phone number &/or e-mail to receive appointment reminder notifications on: ☐ Home ☐ Cell ☐ Text ☐ No reminder *__For email reminder, please see email consent form__					

Private Pay Client Policies and Agreements

_____ Initial

1. **Payment:** Clients who are being treated on a Private Pay basis are required to pay at the time of service.

_____ Initial

2. **Account Responsibility:** I understand that I am responsible for the full payment for these services. Lafayette Physical Therapy will not bill your insurance.

3. **Late Policy:** Please be on time for your appointments. A professional staff member has been scheduled to treat you specifically. If you are late by 10 minutes or more you may be required to reschedule or wait for the next available appointment. If you are unable to be seen due to tardiness you will be charged the no show fee below. If you are running late please call our office as soon as possible so we can attempt to accommodate you at a later time.

_____ Initial

4. **No Show & Cancellation Policy:** Our professional staffing is planned to accommodate scheduled visits. There is a $75.00 charge for no show or same day cancellations. Please provide 24 hour notice for appointment cancellation. LPT may discharge patients who fail to attend their scheduled appointments.

_____ Initial

5. **Overdue Accounts & Fees:** Payment is due upon receipt of a statement or being notified by the front desk. Accounts 30 days or more overdue may be assessed a re-billing fee of $5 for every additional statement sent. Accounts over 60 days overdue may be assessed a late fee of $25 and assigned to a collections agency (currently Transworld Collection Agency). A $25.00 fee will apply to any returned checks.

6. **Cell Phones and Distractions:** As a courtesy to other patients and our staff please silence your cell phone while you are in our office. Please do not allow your phone to detract from your treatment. If you are unable to attend your full treatment due to urgent phone conversations you may be asked to re-schedule. A missed appointment fee may apply.

7. **Children Requiring Supervision:** Please do not bring children to your appointments that require supervision. Your full attention is required for your full treatment. You may bring children who are capable of waiting for you in the waiting room unattended. We appreciate your understanding.

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8. **Release of Liability and Informed Consent:** I have read and understand the enclosed Release of Liability Waiver included in the intake paperwork. I understand the expected benefit of physical therapy and I understand that I can refuse any procedure prior to its performance. I hereby consent to the procedures which may be performed while I am a patient of LPT under the direction of a Licensed Physical Therapist. This may include but not limited to: examination/evaluation, physical testing, application of modalities such as hot/cold pack, electrical stimulation, ultrasound, etc, application of therapeutic procedures intended to improve function including therapeutic exercises, neuromuscular rehabilitation, gait training, manual or mechanical traction, soft tissue mobilization, joint mobilization, and any other procedure under the scope of physical therapy practice.

9. **Informed Consent:** I understand the expected benefit of physical therapy and I understand that I can refuse any procedure prior to its performance. I hereby consent to the procedures which may be performed while I am a patient of LPT under the direction of a Licensed Physical Therapist. This may include but not limited to: examination/evaluation, physical testing, application of modalities such as hot/cold pack, electrical stimulation, ultrasound, etc, application of therapeutic procedures intended to improve function including therapeutic exercises, neuromuscular rehabilitation, gait training, manual or mechanical traction, soft tissue mobilization, joint mobilization, and any other procedure under the scope of physical therapy practice. I give consent to and release Lafayette Physical Therapy, Inc. from liability arising from providing CPR, AED and any other emergency medical assistance in the event of an emergency.

10. **Privacy Acknowledgement:** I understand that I have the right to review LPT's notice of privacy practices prior to signing this document. The full notice is posted in the waiting room and I have read and understand the notice. The notice of privacy practices describes the types of uses and disclosures of my protected health information and is summarized below. I further acknowledge that I have the right to request a copy of the notice.

    Consent to Use and Disclose Health Information: I also understand that when necessary, LPT or anyone affiliated with our organization may contact me at any phone number provided. Your verbal communication and clinical records are strictly confidential. The following are the ways that we use your information and communications: (1) Treatment: information shared with our staff to provide quality treatment and billing, (2) Payment: information on your diagnosis, dates, treatment, etc. shared with your insurance company to process your claims, (3) Internal Administrative Activities: including quality control audits, software updates, etc, (4) Appointment Reminders: may be provided to a phone number or e-mail of your choosing. You may discontinue reminder calls or emails at any time by contacting our office in writing. (5) When required by Law, (6) To inform you of treatment alternatives or update you on relevant products or services offered, (7) Emergencies, (8) When you sign a release to have information shared.

_____ Initial **or N/A**

11. **Permission to Treat a Minor**: I consent to _____ being treated as a patient by LPT. I understand that at times it may be necessary to schedule appointments during school hours and that it is my responsibility to ensure he/she is on time for his/her treatment.

    _____ _____ _____
    Parent or Legal Guardian Name Signature Date

Thank you for choosing Lafayette Physical Therapy for your physical therapy needs. We look forward to a rewarding relationship with you throughout your plan of care. The policies below are important to our relationship and assist us in providing you with the best quality care. Please let our staff know if you have any questions.

I attest that all information I have provided to Lafayette Physical Therapy regarding my condition and personal information is true and correct and I have read and understand the above policies and agreements. A photocopy of this agreement shall be as valid as the original.

_____ _____
Client/Guardian Signature Date