FOUR corners
mind body motion spirit
PHYSICAL THERAPY

Name_____**DOB** _____ **Date** _____

Address_____ **City**_____**State**___ **Zip**_____

Home Phone_____ **Cell Phone** _____ **Work Phone** _____

E-mail Address _____

In Case of Emergency _____ **Phone** _____

Informed Consent for Treatment

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Payment

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Payment is due at the time of service. The fee for service for an initial evaluation is _____. The fee for service for all follow-up visits is _____.

Insurance

We are out of network with all insurance companies. As a courtesy we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. I understand that my insurance forms will be submitted by mail from FOUR CORNERS PHYSICAL THERAPY LLC. We have no contract or agreement with your insurance company. It is your responsibility to follow up on your reimbursements with your insurance company.
Not all insurance plans cover all services. In the event your insurance plan determines a service "not to be covered," you will be responsible for those charges. Please be aware that some insurance companies have a maximum number of visits that you are allowed; some companies also require prior-authorizations.

It is the patients' responsibility to know their physical therapy benefits, check with their insurer if any prior authorization is required and to follow up with our office if it was obtained & visits were approved.

Privacy Notice

FOUR CORNERS PHYSICAL THERAPY LLC maintains the privacy of patient health information. I am aware that a Notice of Privacy Policies is available in the waiting room and that I may ask our office staff or your Physical Therapist for a copy of the notice to take home with me.

I authorize the release of any medical information necessary to process the claim for services rendered to me.

I UNDERSTAND FOUR CORNERS PHYSICAL THERAPY, LLC FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Patient /Guardian Signature Date:

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CANCELLATION POLICY Name _____

Cancellation/No Show/Late Policy:

We understand that unanticipated events occur and that you may need to cancel your appointment. We have adopted the following policies and appreciate your consideration in this matter.

Cancellations

Our practice requires 24 hours notice BUSINESS DAY prior to your appointment; otherwise, you will be charged $50.00. If your appointment is on a Monday, please leave a voice message over the weekend, in order to avoid a cancellation penalty.

No-shows

Anyone who either forgets or consciously chooses to forgo his or her appointment for whatever reason, will be considered a "no-show". **They will be charged for the "full" session** and future service will be denied until payment is made.

Arriving Late

Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session**.

I have read and understand FOUR CORNERS PHYSICAL THERAPY, LLC cancellation policies and I agree to be bound by its terms.

Patient /Guardian Signature Date: _____

Privacy/Information Exchange

Four Corners Physical Therapy – 17 Hanover Road, Florham Park NJ – 07932 P: 973 845 2592

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Email Authorization

FOUR CORNERS PHYSICAL THERAPY, LLC is equipped to relay information to you using email. Due to the "HIPPA Notice of Privacy Practices" we need your permission to communicate with you electronically. Please note, although every effort is made to ensure patient privacy, Four Corners cannot assure confidentiality of information sent electronically. Four Corners cannot be held liable for security risks.

By signing below, you grant permission for practitioners and staff of Four Corners to contact you via email to discuss your care.

Patient Name: _____

Patient DOB: ____/____/_____

Patient Signature: _____

Patient Personal Email: _____

Four Corners will also use this means to send you periodic updates about activities at our office. These might include changes in policies, closing of the office due to inclement weather or emergency, new service offerings, newsworthy health research findings, our Four Corners newsletter, special offers and invitations to events.

PLEASE NOTE: We will never share your email address with anyone.