KREMER
Physical Therapy

Patient Name: _____

(_____) Informed Consent

The patient has the right to informed participation in decisions involving his/her healthcare. This shall be based on a clear concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by the attending therapist. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of the legal representative. Where medically significant alternatives for care or treatment exist, the patient shall also be informed. The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. I understand that the practice of physical therapy is not an exact science and acknowledge that no guarantees have been made to me concerning the outcome of the treatment to be rendered at Kremer Physical Therapy. After reading the above, I hereby consent to receive physical therapy at Kremer Physical Therapy, LLC commencing on the date below and terminating when determined by myself, my physician, or my therapist. I have read and understand this information and its content. I understand that I may revoke my consent at any time and that this decision is mine alone. This consent shall remain in full force and effect until revoked in writing.

(_____) Payment Policy

The payment structure for Kremer Physical Therapy, LLC is based on usual and customary fees for the type of service provided. Kremer Physical Therapy, LLC will not bill insurance and will collect payment via cash, check or credit card. I agree to be financially responsible and obligated to pay Kremer Physical Therapy for the total charges of the services received. Payment for services rendered will be due at or before the time of the scheduled treatment session and payment is expected prior to services rendered whereas Kremer Physical Therapy has the right to refuse treatments rendered. Kremer Physical Therapy, LLC will provide paperwork and codes required should the patient or representative wish to file their insurance on their own. If for any reason an amount for which I am responsible should become delinquent, I agree to pay a rate of 8% per annum. I have read, understand, and agree to abide by the information listed in Payment Policy Statement.

(_____) Therapy Compliance

Effective therapy requires consistency in therapy sessions and home programs. The program the therapist develops with you is based on individual needs and goals with your help. Compliance with this plan will promote optimal recovery and development. If there are excessive cancellations and/or No Shows for scheduled therapy sessions, this will significantly limit your progress and may also limit the potential progress of other patients. Therefore, Kremer Physical Therapy, LLC will maintain the right to discharge a patient should any patient miss 2 consecutive scheduled treatment sessions or 3 sessions total. A notice will be sent to your providers should the therapist deem it necessary. You will be required to contact Kremer Physical Therapy, LLC to be rescheduled for ongoing sessions and/or re-evaluation of needs. I have read and agree to abide by the Therapy Compliance Statement.

(_____) Illness Management

It is the policy of Kremer Physical Therapy that all those attending sessions, whether in office or in home and including therapist, will be fever free for 24 hours and have no episodes of vomiting or diarrhea in the previous 24 hours. By initially here, I am agreeing to comply with the requested policies to best keep my family and the family of my physical therapist as safe as possible. I understand that no restrictions, guidelines, or practices will remove all risk of exposure to viruses and illness. I agree to use my best judgment about what is best for my family and household, including undertaking additional precautions to protect the health of those in my household and those who will be working with Kremer Physical Therapy, including but not limited to cancelling my appointment and paying and fees necessary.

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(_____) Consent to Group Therapy

If you are participating in one of the group programs provided and offered as part of Kremer Physical Therapy, LLC, it is possible that parts of your medical history or health information may be discussed in front of other participants in the group. This will be done with discretion and privacy is always a priority with Kremer Physical Therapy, LLC, but please understand that there may be times within a group setting, where complete privacy may be difficult to achieve and protected health information will be disclosed. If there are times, situations, or circumstances where you need privacy, please let your therapist know and an effort will be made to accommodate this, although it may not be guaranteed. You further agree to keep confidential information learned about other patients during any group therapy session. By signing here, you indicate that you understand and accept the Consent to Group Therapy.

(_____) Missed Appointment Fee

Kremer Physical Therapy, LLC strives to provide excellent customer service and care for each patient. When you schedule an appointment, that time is held for you. In the event that you must miss an appointment, Kremer Physical Therapy, LLC requires a 24 hour notice be provided. If less than a 24 hour notice is provided, the cancelled appointment will be subject to a $30 cancellation fee. This fee will also automatically be charged for any appointment where the patient fails to give prior notice.

(_____) No Surprise Act/Good Faith Estimate

Under the law, health care providers are to give patients who don't have insurance or who are not using their insurance, an estimate of the bill for medical items and services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. This paragraph will serve as your Good Faith Estimate, and by initially here, you acknowledge having received it and reading the contents here. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. For more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call the number listed on the website. Your fees for Physical Therapy services are here: Initial Physical Therapy Assessment (home visit): $270; Physical Therapy Follow Up (hone): $175; Initial Physical Therapy Assessment (office): $215; Physical Therapy Follow Up (office): $120

(_____) Shared Medical Information

Kremer Physical Therapy will not share your information without permission from you. Initialing here states that you have read this section and understand your medical information and that of your minors is yours to share. However, if you would like to give Kremer Physical Therapy the ability to communicate with other health care providers or family members, please list them below. Typical providers that are listed are coparents or other primary caretakers, referral source, pediatricians and family care providers, dentist/oral surgeons, lactation consultants, chiropractors, cranial sacral therapist.

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(_____) Newsletter Opt In

Kremer Physical Therapy sends out a monthly newsletter full of information on promoting development in babies and toddlers, parent and child health, community happenings and family activities, parent approved client highlights, updates on Kremer Physical Therapy, toy highlights, deal highlights, etc. If you would like to opt in to receive this email newsletter, please list what emails you would like to have included in this newsletter.

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Patient or Representative Signature Date

Printed Patient or Representative Name Relationship to Patient