1794 Olympic Parkway #140
Park City, Utah 84098
(435) 575-0345

CONDITIONS AND CONSENT FOR PHYSICAL THERAPY

As you have consulted with Mountaintop Physical Therapy & Wellness Center, Inc. ("MPT") and have decided to receive physical therapy services from MPT, IT IS IMPORTANT THAT YOU, THE PATIENT, READ THIS CONSENT FORM CAREFULLY AND OBTAIN ANSWERS TO ANY QUESTIONS THAT YOU MAY HAVE.

Consent for Treatment

Physical therapy involves the use of several modalities of evaluation and treatment. Accordingly, at MPT we use a variety of procedures and treatments to help us to try and improve your physical function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. As patient responses to a specific form of treatment can vary widely from patient to patient, it is not always possible to predict responses to a specific form of treatment. Therefore, MPT cannot guarantee any reaction or success to a given form of treatment. There is also a risk that your treatment may result in pain, injury, or may aggregative a previous condition. You have the right to inquire as to the form of treatment based upon your history, diagnosis, symptoms, and testing result. You may also discuss with your physical therapist the potential risks and benefits of a specific treatment and possible alternative treatments. You have the right to decline any portion of treatment at any time or during your treatment sessions. Your physical therapist stands ready to answer any questions you may have regarding a given course of treatment, type of exercise, associated risks, and possible alternatives. This Consent Form is based upon your informed decision to participate in the proposed treatment plan for physical therapy services as explained to you by MPT.

By signing below, I hereby authorize and consent for MPT to provide physical therapy services in accordance with the proposed treatment plan, which has been explained to me in a way that I can understand. I affirm that MPT has discussed with me, in words that I can understand, my diagnosis, conditions, the reasons for and benefits of the proposed plan of physical therapy services, the reasonable likelihood of its success, the possible consequences of not choosing this plan, the possible risks associated with this plan, and possible alternatives and risk associated with those alternatives, as well as my goals of recovery and any potential problems that might arise during treatment. I understand that I am giving this consent with the understanding that any treatment/ procedure involves some risks and hazards, and that no guarantees have been made to me as to any treatments or examinations by MPT or supporting staff. I understand that by failing to sign or by or revoking this consent, MPT may refuse to treat me as permitted by 45 C.F.R. § 164.506.

I CERTIFY THAT I HAVE DISCLOSED COMPLETELY AND TRUTHFULLY ALL OF MY MEDICAL HISOTRY; MY COMPLAINTS AND/OR AILMENTS; AND MY USE OF ALL PRESCRIPTION AND NON-PRESCRIPTION DRUGS, VITAMINS, MINERALS, AND DIETARY SUPPLEMENTS. I HAVE CAREFULLY READ AND FULLY UNDERSTAND THIS CONSENT FORM AND I VOLUNTARILY AUTHORIZE AND CONSENT TO THE PROPOSED PLAN FOR PHYSICAL THERAPY SERVICES.

INITIALS _____

Patient's Financial Responsibilities

General Conditions:

- I understand that I am responsible for checking my own insurance benefits before receiving treatment and that I am ultimately responsible for my bill if insurance or other entity denies payment.
- If I so choose, MPT will bill my insurance as a courtesy. We encourage you to follow up with your insurance company on all of your claims to ensure timely processing and avoid any other delays.
- It is my responsibility to provide MPT with complete and accurate insurance information in order for us to bill, as well as any other special requirements by the insurance company.
- If my insurance changes at any time, it is my responsibility to inform MPT and provide new insurance information, or I will be responsible for my balance.
- I understand that COPAYS MUST BE PAID AT THE TIME OF SERVICE.
- I agree to pay finance charges, attorney fees and costs, collection costs, and any additional fees incurred by MPT in collecting any amount due on my account and possibly 40% of the principal amount owed to MPT. *See* Utah Code § 12-1-11.
- I agree that if I cancel less than 6 hours before a scheduled appointment I will pay a cancellation fee of $25.00.

INITIALS _____

Referral:

A physician's referral for physical therapy treatment is required by some insurance companies for reimbursement. Physical therapy services can be rendered without a referral but cash payment will be required if your insurance carrier does not reimburse without a referral.

Workers' Compensation:

If Workers' Compensation denies coverage of your physical therapy treatments for any reason, you may determine whether you would like us to bill your private insurance or bill you directly for services.

Lien Patients:
If you are a patient that is on a lien, please stay in contact with your attorney so that they know the progress of your rehabilitation. The patient must also provide medical insurance information, in the case that the lien does not pay due to objections. In that case, you may determine whether you would like us to bill your private insurance or bill you directly for services.

Secondary Insurance Billing:
We will bill secondary insurance once the primary carrier has responded. If the primary insurance has made payment directly to the patient, we must have a copy of the Explanation of Benefits in order to bill the secondary carrier. In the event that the primary carrier has not responded to our claim, we will not act to collect from the secondary carrier on the patient's behalf. In the event that industrial or auto insurance exhausts or refuses to pay, the patient will be given the opportunity to decide whether to authorize MPT to bill their personal health insurance, or bill them directly.

Patient Balances Not Paid Within 30 Days:
We encourage patients to pay their balance within 30 days however, we will allow up to 60 days for patients to pay their patient balance in full. All accounts not paid by 60 days will be assessed a late fee of 1.5% interest on the balance. Accounts not paid in full by 120 days will be assessed a 20% handling fee of the current balance and turned over to a collection agency. The balance is the responsibility of the patient or responsible party whether insurance pays or not.

Patients Without Insurance:
If the patient does not have insurance, payment for services rendered will be expected at the time of service.

Tricare/CHAMPVA Authorization:
I request payment of authorized benefits to MPT on my behalf for any services furnished me by MPT. I authorize any holder of medical or other information about me to release to undersigned signs this document either as the patient or as the agent representative of the patient authorized to execute this document and to accept and agree to its terms on behalf of the patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I understand what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

Medicare/Medicaid Certification.
I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made on my behalf directly to MPT or other providers for whom the facility is authorized to bill in connection with its service.

BY SIGNING BELOW, I HEREBY GUARANTEE PAYMENT OF ALL PHYSICAL THERAPY CHARGES AND OTHER FEES FOR TREATMENT PROVIDED TO ME BY MPT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCLUDING BY NOT LIMITED TO ALL CO-PAYMENTS, DEDUCTIBLES, AND EXPENSES NOT COVERED OR PAID BY INSURANCE.

INITIALS _____

Acknowledgement of Privacy Practices
By signing below, I hereby acknowledge receiving a copy of MPT's "Notice of Privacy Policies" in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. §§ 160, 164. I understand that if I would like more information about MPT's privacy practices or to file a complaint I can contact MPT, attn: Privacy Officer at 1794 Olympic Parkway #140, Park City, Utah 84098.

INITIALS _____

I HAVE CAREFULLY READ AND FULLY UNDERSTAND THIS TWO-PAGE CONSENT FORM. DO NOT SIGN THE BELOW UNLESS YOU HAVE READ AND THROUGLY UNDERSTAND THIS FORM.

_____ _____
Patient's Printed Name Date

_____ _____
Patient Signature or Parent/Guardian if patient is under 18 Relationship to Patient

_____
Witness