Visions At Home Physical Therapy
105 Northgate Rd., Suite E • Natchez, MS 39120
Phone: 601 - 568 – 1313 • Fax: 601 – 653 – 9261
Website: visionsathomept.com

OUTPATIENT THERAPISTS MAKING HOUSECALLS

Informed Consent Form

Informed Consent

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist, physician, and/or referring provider. I understand that it is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. I have been provided with adequate, intelligible information about the proposed therapy including but not limited to the following:

- A description of the intervention/treatment to be provided
- A clear explanation of the risks which may be associated with the therapy
- Expected benefits from the therapy
- Anticipated time frames and costs
- Reasonable alternative to the recommended therapy

I have read this consent and fully understand and accept its terms and conditions. This consent shall be ongoing for a period not to exceed one year.

_____Date_____

Signature of Client (or person authorized to consent for client/relationship)

_____Reason, if patient was unable to consent

Assignment and Release

I hereby authorize my insurance benefits be paid directly to Visions At Home Physical Therapy and understand that I am financially responsible for copays, deductibles, and non-covered services. I understand that if Visions At Home Physical Therapy does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I understand that copays and deductibles are due at the time of service and are to be paid over the phone with the billing department at 601-568-1313. Copays and deductibles that are not paid at the time of service will be included in my monthly statement. I understand that if I am experiencing a financial hardship that I am advised to contact the billing department to make special payment arrangements.

I understand and agree with Visions At Home Physical Therapy 's no-show/cancellation/ rescheduling policy: I may be charged a $25.00 fee in the event that I miss an appointment, cancel and/or reschedule in less than a 24-hour period. I may be discharged from therapy in the event of two cancellations with less than 24 hours notice and/or two no-shows during a 6 month period. I understand and agree with Visions At Home Physical Therapy 's non-sufficient funds policy: I will be charged a $25.00 fee for checks returned for non-sufficient funds. I authorize the Referring Provider and/or Visions At Home Physical Therapy to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge.

_____Date_____

Signature of Client (or person authorized to consent for client/relationship)