# 2023 HIPAA CONSENT FORM

The Notice of Privacy Practices provides information about how we may use and disclose protected Health Information concerning you. You have the right to review our notice before signing this consent or at any time during your treatment, should a question arise. As provided in our notice, the terms of our notice could change, and we will notify you of any changes. You have the right to request that we restrict how protected health information concerning your case is used or disclosed for treatment, payment, or health care operations and we will do our best to accommodate that request. We ask that your request be in writing.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Please see HIPPA information at our office or at [www.hhs.gov/hipaa](http://www.hhs.gov/hipaa) Please sign below indicating you have reviewed this information and feel free to request your own copy from our office at any time.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CONSENT FOR TREATMENT

I hereby consent to a Physical Therapy Evaluation and Treatment by my assigned Licensed Therapist at Chicago Physical Therapists as recommended by my Physician, Midwife, or other appropriate referring practitioner or as a self-referral per current Illinois law. I hereby authorize Chicago Physical Therapists to release information related to insurance claims. I understand that it is my responsibility to verify coverage with my insurance company.

I am financially responsible for charges incurred and payment will be made on the day that services are rendered unless my insurance is BCBS PPO or Blue Choice. If I have BCBS PPO or Blue Choice. I consent to billing of co-payments and co-insurance done by Chicago Physical Therapists after processed by BCBS. If I am insured by a group other than BCBS PPO or BCBS Choice, I understand that billing of all visits will be done upfront. I acknowledge that this includes billing $195 for an 1hour Initial Evaluation and $640 if I choose to purchase a package of four visits, or $175 for each follow up visit. Final payment determination will be made once your claims are processed.

This signed document assigns benefits to Meredy Parker Physical Therapy LLC (Chicago Physical Therapists) for BCBS PPO and Blue Choice approved plan members only.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_

**BILLING AGREEMENT**

Chicago Physical Therapists sends out Invoices via email twice monthly and collects any remaining balances at the end of each month. Please identify your preferred payment method by checking one of the options below:

I prefer to pay my bill through Zelle® to Meredy@ChicagoPT.org

I prefer to pay by check

Please run card on file automatically

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that if my bill is not paid within 5 days of the second invoice of the month (and I have not contacted Chicago Physical Therapists asking them not to run the card on file) that the card on file will be charged for the full amount of the Final Invoice. I understand that if I am not receiving an Invoice in my email, it is my responsibility to contact Chicago Physical Therapists to inform them of this.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note: \*Sometimes invoices can be found in junk mail or spam folder depending on your email settings

\*For all Billing questions please email Billing@ChicagoPT.org.

# CANCELLATION/ NO SHOW/ LATE POLICY

A $75.00 cancellation fee will be charged to your credit card on file if you do not show up for your appointment or if you cancel less than 24 hours prior to your scheduled appointment time. Subsequent incidents will result in a full $175.00 fee to cover your missed treatment. If you are 15-30 minutes late to your appointment you will be charged $50.00. Please note these fees will be charged automatically to your account. Insurance cannot be billed for this fee. It is important that I have adequate time to fill your spot should you not be able to attend.

Thank you for your cooperation and understanding.

Please sign here to acknowledge notification:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_