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|  | | **CLIENT & PATIENT AGREEMENT** | | | |
| NAME: | | | DOB: |
| ADDRESS: | | | |
| PHONE #s: | EMAIL: | | |
| SERVICES YOU ARE INTERESTED IN: | | | |
| HOW DO YOU PREFER WE CONTACT YOU? | | | |
| ***FOR PHYSICAL THERAPY ONLY*** | | | |
| DIAGNOSIS: | | REFERRING MD: | |
| SURGERY DATE: | | PCP: | |
| INS. CO. & ID#: | | | |

WELL BEINGS will bill insurance companies with which we participate for services rendered. We cannot bill insurance companies that we do not currently accept. Co-pays, deductibles and co-insurances may apply as per your plan. Well Beings does not get involved in disputes between you and your insurance company. Unless other arrangements are made, payment is due at time of service. WELL BEINGS will provide you with a receipt/superbill for services rendered if you will be applying for out-of-network reimbursement with your insurance company at no additional cost. Out-of-network benefits are different across all insurances and plans; it is the patient’s responsibility to learn their particular benefit.

* I understand WELL BEINGS protects my personal information and only shares for the purposes of my care (i.e. your doctor or insurance company). Any release of medical information for other purposes must be authorized by me. I understand that a statement of Privacy Practices in accordance with HIPAA compliance is available to me.
* Release of medical records to outside parties will require additional consent and possibly a fee. I will notify WELL BEINGS staff in advance if this is needed.
* I understand that my care is dependent upon my attendance and compliance with my plan. Missed appointments could affect my outcome, and late cancellations prevents WELL BEINGS from helping others. I understand that repeated late cancels (less than 24 hours) or no-shows could result in not being able to schedule appointments ahead of time. In these cases, I may call day-of for availability.
* I understand that WELL BEINGS’ outcomes for physical therapy and wellness services are dependent on many factors, but that services will be provided to the best of our ability in a professional manner within the allowable scope of our practice. Expected and desired outcomes will be discussed but cannot be guaranteed.
* I consent to treatment and services rendered by WELL BEINGS staff. My plan, goals and all treatments will be discussed with me before they are implemented. Medical care will be provided for as long as is medically necessary, as determined by your therapist. Visits outside of medical necessity (i.e. preventative, wellness or maintenance visits) *may not be eligible* for reimbursement by your insurance company.
* I understand that WELL BEINGS exercises Universal Precautions to maintain a clean, sanitary clinic environment. All high-touch surfaces are sanitized between patients/clients and all equipment is sanitized before and after it is used. I understand that, as long as is necessary and prudent, face coverings are required inside the clinic.

***I have read and I understand the agreement above.***

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Signature

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Date