In Motion Therapy™

Authorization to Treat

I voluntarily consent to therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize In Motion Therapy to provide such treatment. MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION. I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES RENDERED.

Initials_____

PAYMENT AUTHORIZATION: I understand that all balances designated as 'the patient's responsibility' such as co-insurances, copayments and deductibles are due and payable to In Motion Therapy. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. As part of working with my insurance carrier, I recognize that In Motion Therapy may be provided with information about my insurance coverage, and that on occasion In Motion Therapy may share some of this information with me. However, I understand In Motion Therapy is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. This is not a guarantee of benefits.

Initials_____

INSURANCE BENEFITS ASSIGNMENT: I authorize that the payment of my insurance benefits be made directly to In Motion Therapy for all services delivered; if I am paid directly, I will promptly pay In Motion Therapy all monies paid to me.

Initials_____

HIPAA PRIVACY POLICY: My signature below indicates that I have been given the Notice of Privacy Practices for In Motion Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to In Motion Therapy to release any of my protected healthcare information.

Initials_____

CANCEL/NO SHOW POLICY: We ask that if you are unable to keep your appointment, that a 24-hour notice is given. We do understand emergency situations may arise and ask that you call as soon as possible. Upon 2 consecutive No Shows, all future appointments will be cancelled, and we will require same day visit scheduling.

Initials_____

RECORD RELEASE: I am aware that In Motion Therapy may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care.

Initials_____

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REVIEW AND INITIAL BELOW ONLY IF APPROPRIATE

MEDICARE PATIENTS ONLY: Are you currently, or in the last 30 days have you received any type of Home Health Services, therapy from a home health care agency, transitional care facility, or nursing home?: YES NO
If YES, we cannot treat you until you have been discharged. Medicare will not pay our services. You may request Medicare Cap information.

Initials_____

SELF REFERRAL OR OUT OF STATE REFERRAL: I understand that if I have been referred by a physician who is not licensed in the state of MN and I am being treated at a clinic in MN, I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a physician who is licensed in the state of MN. The same 90 day rule pertains if I have not been referred by a physician and I am self-referring.

Initials_____

PAYMENT AUTHORIZATION – PROMPT PAY: Your services will not be billed to your insurance company or do not qualify for coverage. Charges must be paid in full at the time of service in order to receive the prompt pay discount. The amount charged is determined by the case's complexity. If a supply or orthotic is issued, there will be an additional charge. I do not want my services billed to an insurance company, and will not do so myself.

Initials_____

TELEHEALTH/E-VISIT APPROVAL: I approve the possibility of being seen by a clinician via telehealth for some portion of my care.

Initials_____

(OPTIONAL) SOCIAL MEDIA CONSENT: I give my consent to In Motion Therapy, Inc for the participation in interviews, the use of quotes, the taking of photographs, videos, or other forms of media with the right to edit, use, and resume said media for advertising purposes or promotion within social media (Facebook, Instagram, ect.) without expectation of compensation or other remuneration now or in the future.

Initials_____

Patient Signature _____

Date _____