Patient or Guardian Agreement:

◯ I acknowledge that ElmTree Wellness Center and Physical Therapy may disclose protected health information (PHI) for the purposes of payment, treatment and healthcare operations (please refer to Elm Tree Wellness Center's Notice of Privacy Practices for additional information).

Consent to Treatment:

I consent to receive outpatient rehabilitation therapy services and any ancillary services that are deemed medically necessary or appropriate by my physical therapist and/or treating physician. However, I am aware that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy.

Signature of Patient or Guardian: _____ Date ____/____/_____

Financial Responsibility:

I agree to pay ElmTree Wellness Center all amounts that are due and owing for services provided which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf for services rendered. In the event that this account is referred to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney's fees.

I also hereby authorize my insurer to pay any and all benefits for services provided to the patient directly to ElmTree Wellness Center.

Signature of Patient or Guardian: _____ Date _____/_____/_____

Ability to Pay:

If you believe you are unable to pay for health care services you can provide information regarding your ability to pay. We will work with you to determine if you are eligible for a payment plan, discounted services, or a sliding scale discount (which is based on Federal Guidelines for family size and income).

Self-Pay:

If we do not contract with your insurance, you do not have insurance and are otherwise ineligible for discounted services based on ability to pay, or if you have exhausted your benefits for the year, then you may

be eligible to receive services on a cash-pay (i.e., self-pay) basis.

Cancelling an Appointment:

Please give 24-hour notice when cancelling an appointment. We realize this is not always possible and ask that you call immediately to reschedule if you cannot make it. Repeated cancellations may result in Day-Of scheduling only.

Late Policy:

Please call and notify us if you are going to be late. This will allow our staff to make appropriate accommodations so you can be seen as quickly as possible when you arrive. If you do not notify the office of a late arrival, we cannot guarantee you will be seen by the provider with which you were scheduled. If you are more than 15 minutes late for your appointment, you will be given the option to wait for another appointment time that day or reschedule for a future appointment.

No Show Policy:

Please make every effort to keep your scheduled appointment; that time has been reserved for you. If you do not show up and do not call to cancel, it prevents us from seeing other patients. ElmTree retains the right to charge a $50 no show/repeated cancels charge. This will charge is not covered by insurance and will be the responsibility of the patient.

Returned Checks:

A returned check will result in a minimum $25 service charge in addition to any fees that your financial institution may charge you. In the case of a returned check, ElmTree Wellness Center may require all future payments to be made by cash or credit card.

I acknowledge and agree to the above policies.

Signature of Patient or Guardian: _____ Date____/_____/_____

Patient Notification Policy:

I, the undersigned, hereby authorize ElmTree Wellness Center to disclose my appointment information by the following methods of communication and I assume all responsibility for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable.

Answering Machine ( )_____

Voice Mail ( )_____

Text Message ( )_____

E-Mail ( )_____

Signature of Patient or Guardian: _____ Date _____/_____/_____

If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization. I further agree to be responsible for notifying ElmTree Wellness Center if any of the foregoing change.

I, the undersigned, hereby authorize ElmTree Wellness Center to disclose my PHI to the person(s) named below.

Name	Relationship	Phone #
Name	Relationship	Phone #

Signature of Patient or Guardian: _____ Date _____/_____/_____