Informed Patient Consent & Financial Responsibility

I have read and understand the "Patient Bill of Rights" which was made available for me to read.

I understand that any co-pay, deductible and/or co-insurance that I am responsible for, is due at the time of service and that it is my responsibility to pay for any services that my insurance company does not pay for. It is my responsibility to work with my insurance company to thoroughly understand my insurance policy and I understand that AVORA is not at fault should my insurance company provides inaccurate information when determining my benefits.

I understand that liability action against someone else is not a reason for delaying payment of my bill. I also understand and agree that this Informed Patient Consent & Financial Responsibility represents evidence of indebtedness, and I agree to pay reasonable attorney's fees and other expenses incurred by AVORA in the case of collection or litigation. I further understand that no animal other than a service dog is permitted in the clinic and I am responsible for the behavior, actions, damage, and legal liability created by my service dog.

I understand that failing to show up for my appointment, cancelling on the same day of my appointment, or routinely running late may cause me to lose my right to schedule appointments in advance or cause me to be discharged.

I understand that workers compensation patients who fail to show up for an appointment or cancel on the same day cannot be charged any fees, therefore workers compensation patients must reschedule for the same week or may be discharged for failure to adhere to the prescribed Plan Of Care.

I understand that my participation in physical therapy is voluntary and by choosing to participate, I am consenting to all rendered services. If I am the parent or guardian of a minor patient (under the age of 18), I understand that I am responsible for consent of treatment and full payment. I also agree to accompany my minor with each visit.

If you receive home health care, hospice, speech therapy, or attend physical Therapy elsewhere, you must inform us immediately! If you do not, we cannot coordinate your care and you may receive a bill due to denied claims.

AVORA is a participating Medicare provider and is required to accept the contracted rates established by Medicare. Medicare utilizes an 80/20 coinsurance. This means that Medicare covers 80% of their allowed charges, up to the therapy cap, provided services are medically necessary and treatment is approved by a physician or approved provider. You (the patient), or your secondary insurance, are responsible for the 20% Medicare coinsurance.

List any individual(s) that you authorize us to release your medical records and billing information to:

Person's Name _____ Relationship to patient _____

We occasionally take photographs and video inside our clinic. If your photo is taken or you are captured on video and the media is well suited for marketing material, do we have your permission to use it? Please circle yes or no. ***YES - NO***

By signing, I agree that I have read, understand, and accept the conditions stated above.

Patient or Legal Guardian's Signature: _____ **Date**: _____

Patient's Bill of Rights

Every patient shall have the following rights & responsibilities:

(1) To be treated with consideration, respect, and full recognition of personal dignity and individuality;

(2) To receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and State statutes and rules;

(3) To understand all charges for services rendered;

(4) To have on file in the patient's record a written or verbal order of the referring physician, if required, containing any information as the referring physician deems appropriate or necessary, together with the proposed schedule of medical treatment;

(5) To receive respect and privacy in the patient's medical care program. Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly, as reasonably allowed within the limitations of the structural layout of the facility. Personal information and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, except as needed in the case of the patient's transfer to another health care provider or as required by law or third-party payment contract;

(6) To refuse treatment. Participation in physical therapy is voluntary. In addition, physical therapy may be discontinued with repeated evidence of poor compliance, poor attendance or failure to pay for services rendered;

(7) To receive from the administrator or staff of the facility a reasonable response to all requests;

(8) To present grievances and recommend changes in policies and services without fear of reprisal, coercion, or discrimination;

(9) To participate in establishing the plan of care, under the guidance of the evaluating Physical Therapist, to include treatment rendered and goal setting.