CONDITIONS OF ADMISSION AND CONSENT

Patient Name	Patient Date of Birth
Address	Phone Number

REQUEST FOR PROVISION OF SERVICES
The undersigned, being the above-named patient (the "Patient"), his/her guardian or representative payee, understands that by signing this *Conditions of Admission and Consent,* you agree to receive medical care/services provided by Northcutt Physical Therapy and Wellness.

ACKNOWLEDGEMENT OF MEDICAL RESPONSIBILITY AND INFORMED CONSENT
The undersigned, as or on behalf of Patient, understands that (1) Patient is under the supervision and control of his/her attending physician; (2) Patient physician has prescribed the medical care and/or services noted as part of Patient's treatment; (3) Northcutt Physical Therapy and Wellness' services do not include diagnostic, prescriptive or other functions typically performed by licensed physicians; and (4) Patient's physician is solely responsible for diagnosing and prescribing medical equipment, supplies, services or other therapies for Patient's condition and for otherwise controlling Patient's medical care. The undersigned has been informed by Patient's physician of the possible increased risks associated with in-home care, including possible delays in receiving treatment for life threatening conditions as a result of being outside the hospital setting. The undersigned has discussed his/her concerns with Patient's physician and has had all associated questions answered to his/her satisfaction.

AGREEMENT TO PAY
The undersigned agrees to pay for all equipment/supplies/services provided by Northcutt Physical Therapy and Wellness to Patient. The monthly balance due will be that portion of Northcutt Physical Therapy and Wellness' charges not paid by insurance or any other payer and will include coinsurance, co-payment and deductible amounts, as well as amounts due for non-covered equipment/supplies/services rendered to the Patient by Northcutt Physical Therapy and Wellness. The undersigned agrees to pay the balance due in full upon receipt of an invoice from Northcutt Physical Therapy and Wellness. If payment is not made, Northcutt Physical Therapy and Wellness will pursue its normal collection policy. Payment of co-pay and co-insurance payments are due at the time service is provided.

CANCELLATION POLICY
There is a cancellation fee of $55 for any no show or any appointment cancelled within 24 hours of the scheduled appointment time. Please provide as much notice as possible when moving and canceling appointments.

AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER INFORMATION
Patient's insurer(s), Physician's and any other third party which provide Patient with coverage or care are hereby authorized, by or on behalf of Patient to disclose to Northcutt Physical Therapy and Wellness any information regarding such coverage including, but not limited to (1) payment made by such insurer(s) or third party payer(s) to Patient, the undersigned or to any other person or entity for services/supplies rendered by Northcutt Physical Therapy and Wellness to Patient; and (2) the scope and extent of Patient's coverage from time to time. The undersigned, as or on behalf of Patient, hereby authorizes (1) all medical personnel to disclose information to Northcutt Physical Therapy and Wellness concerning Patient's medical history and condition as it may relate to the services/supplies provided to Patient by Northcutt Physical Therapy and Wellness; and (2) any holder of medical or other information about Patient to release to the Center for Medicare and Medicaid Service (or any successor) and its agents, to any other third party payer including without limitation Medicare, Medicaid, CHAMPUS or private payers, and to Northcutt Physical Therapy and Wellness any information needed to determine applicable benefits to process claims for equipment/supplies/services provided by Northcutt Physical Therapy and Wellness and/or to conduct quality assurance or utilization reviews. This release shall continue until revoked in writing by Patient or the undersigned.

ASSIGNMENT OF BENEFITS
The undersigned, as or on behalf of Patient, hereby requests that payment of authorized benefits be made to Northcutt Physical Therapy and Wellness, and authorizes Northcutt Physical Therapy and Wellness to collect directly all public and private insurance coverage benefits due, for any equipment/supplies/services furnished to Patient by Northcutt Physical Therapy and Wellness. In the event benefits payments due Northcutt Physical Therapy and Wellness are paid directly to Patient or the undersigned, the payee will immediately and without request from Northcutt Physical Therapy and Wellness endorse and remit to Northcutt Physical Therapy and Wellness all such benefit payment checks. On assigned Medicare claims, Northcutt Physical Therapy and Wellness agrees to accept the applicable Medicare carrier's allowable amount as payment in full for covered equipment/supplies/services.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
The undersigned, as or on behalf of the patient, hereby acknowledge that they have received the Notice of Privacy Practices from Northcutt Physical Therapy and Wellness and have been provided an opportunity to review and understand it's contents.

MISCELLANEOUS
The undersigned certifies that the information provided to Northcutt Physical Therapy and Wellness by or on behalf of Patient under Medicare (Title XVIII of the Social Security Act) and/or any other public or private health insurance is correct. Patient if physically and mentally competent, must sign this *Conditions of Admission and Consent* on his/her own behalf": If Patient cannot sign for himself/herself, the source of the undersigned's authority to sign on behalf of Patient must be stated. This *Conditions of Admission and Consent* is used in lieu of the Patient's or his/her representative's signature on the "Request for Payment" HCFA-1500 and on other health insurance claim forms requiring signature and thus, is an extension of those forms. Any person who misrepresents or falsifies information making a Medicare claim may, upon conviction, be subjected to fines and imprisonment under Federal Law. Penalties may also result from falsification or misrepresentation of other health insurance claims. A copy of this *Conditions of Admission and Consent* may be used in place of the original.

The undersigned certifies that (1) he/she is the Patient or is duly authorized to execute this *Conditions of Admission and Consent* and accept its terms on behalf of Patient and (2) he/she has read the foregoing and received a copy of this *Conditions of Admission and Consent,* including a copy of *Patient Rights and Responsibilities* on the reverse side hereof.

X _____
Patient Signature Date

_____
Patient Representative Relationship to Patient

X _____
Patient Representative Signature Date

Patient Rights

As a patient of Northcutt Physical Therapy and Wellness, you have certain rights and responsibilities as a patient.

You have the right:

To be treated with dignity and respect.

To know the names and professional status of the people providing you service.

To privacy and confidentiality regarding your care.

To receive accurate information about your health and to participate in choosing the most appropriate form of treatment, with your doctor's and therapist's consent.

To receive education and training in usage of your supplies and/or equipment.

To be informed of effectiveness, possible side effects or problems related to your treatment.

To select or change your healthcare provider.

To information regarding services and the costs billed to you and/or your insurance company.

You have the responsibility:

To seek the appropriate medical attention in case of an emergency.

To be honest about your past medical history.

To be respectful of policies and procedures performed by Northcutt Physical Therapy and Wellness employees.

To keep appointments or to cancel with appropriate prior notice.

To question any policies or procedures that you do not understand.

To follow medical advice and instruction to the best of your ability.

To report any changes in symptoms or failure to improve.

To provide clear and useful feedback regarding your care.

To pay any charges incurred by you.