PT360
EXCELLENCE IN MOTION

www.pt360atl.com

Health Insurance Information

PT360 provides quality, easy to access individualized specialty care that requires adequate time with our patients. All sessions are at least 50 minutes one-on-one with a licensed, experienced Physical Therapist. In order to provide you with this level of service PT360 is a fee-for-service provider. We offer significant value when compared to other providers, by providing four times as much one-on-one time per session and often require half as many total visits during the course of your treatment.

Please check your out-of-network Physical Therapy benefits prior to your visit. We courtesy bill all insurance claims. In some cases, you will be able to receive partial reimbursement from your insurance company. Most Medicare claims are reimbursed at 50%-90%.

We offer easy payment options for those with high deductible and/or health savings account/flexible spending accounts.

A 15-minute complimentary phone consult can be scheduled upon request at 678-430-8107.

Commercial Insurance/Self Pay/Medicare Replacement Plan

Initial Evaluation: $209
Includes comprehensive PT evaluation and treatment
Follow up Treatments: $195
*** We courtesy bill your insurance claims. Some plans reimburse a portion of these charges.

Medicare

Initial Evaluation: $184.75
Includes comprehensive PT evaluation and treatment
Follow up Treatments: $140.50
*** We courtesy bill your Medicare/Medicare Supplement claims. Most claims are reimbursed at 50%- 90% of our fee.

I,_____, acknowledge and understand the above cancellation policy.

_____ _____
Signature of the Responsible Party Date

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Patient Rights Information

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION.

USES AND DISCLOSURES OF HEALTH INFORMATION

PT360 uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, PT360 may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

PT360 may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, PT360's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PT360 may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our facility. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. PT360 will consider all such requests on a case-by-case basis, but the company is not legally required to accept them.

PT360's LEGAL DUTY

PT360 is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

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Patient Information Consent Form

I,_____(Print Name), do hereby acknowledge that I have been given a copy of Physical Therapy 360 degrees, LLC's (dba PT360) Notice of Patient Information Practices and Rights.

Access to Protected Health Information (PHI)

I hereby authorize the following individual(s) to receive or discuss information pertaining to my medical condition(s), release medical records, or discuss billing: ☐Not Applicable

Name:_____ Relationship:_____

Name:_____ Relationship: _____

Patient Privacy Notice

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers.
- Healthcare Transaction & Code Sets for transmitting data electronically.
- Privacy regulations over disclosure and use of health information.
- Security regulations over protections of electronic health information.

It is our policy to not release confidential and/or unauthorized information by home telephone, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the voicemail picks up, we will not leave a message if the name or telephone number on the recorded message does not match your name or identity. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I,_____(Print Name), hereby authorize Physical Therapy 360 degrees, LLC (dba PT360) staff to leave medical information pertaining to my care by telephone, email or voicemail and will assume responsibility to notify them whenever this information changes.

_____

Signature Date

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Informed Consent To Treatment

The term “informed consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. The clinical provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

POTENTIAL RISKS AND POTENTIAL BENEFITS:
You may experience an increase in your current level or pain or discomfort, or an aggravation of your existing injury. The discomfort may be temporary and will probably subside in 24 to 72 hours. You may also experience an improvement in your symptoms, an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility, and endurance in your movements. You may experience decreased pain as well. You will have greater knowledge on managing your condition and the resources available to you.

Dry Needling You may have dry needling performed during your physical therapy care. Dry needling is not acupuncture. Please make sure you are properly hydrated and have eaten before having dry needling. Please talk to your therapist if you have any medical conditions that may contraindicate dry needling. This may include but is not limited to blood and bleeding disorders, HIV/AIDS, pregnancy, psychological disorders, history of heart attack or stroke.

_____

Signature Date

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To Our Valued Clients:

In an effort to improve our accessibility to clients who may be on a waitlist, we will be implementing a new cancellation policy. When scheduling, we ask that you please make absolutely certain that you will be able to make your appointment.

CANCELLATIONS:
In the event that you need to cancel your scheduled appointment please provide **at least 48 hours** notice to avoid a **$195 cancellation fee (No Exceptions).** Saturday or Sunday calls or texts for Monday appointments **ARE NOT** considered adequate notice because we are not open on weekends.

NO SHOWS:
Any no-show appointment will be charged a **$195 no show fee** and must pre-pay for the next appointment in order to reschedule. **No exceptions**.

We will keep your credit card on file in our secure processing system (Square) so that we can use it for office visits and/or cancellations. Please discuss with our office staff if you wish to provide another means for payment in case of cancellation.

I understand and agree to comply with PT360's cancellation policy as specified above. I understand that I will be charged for no shows and cancellations made within 48 hours of a scheduled appointment. I understand that this is so that other clients may benefit from our services if I cannot keep my scheduled appointment.

_____ _____
Signature Date

I agree to allow PT 360 to keep my credit card information on file in our secure payment processing service- Square.

_____ _____
Signature Date