Unbridled
Rehabilitation Services

Personal therapy. Powerful results.

(410) 970 -2400 Office (410) 774-4090 Fax www.unbridledrehab.com

Client Consent

Client name: _____

I, _____ acknowledge that my son/daughter is experiencing a condition requiring physical therapy/occupational therapy/speech therapy. I so hereby voluntarily consent to:

A. Such established treatment plans which include procedures and medical treatments as ordered by _____ , who is my child's referring physician. Other physicians and/or therapists involved in my child's care that I give Unbridled Rehab permission to discuss his/her medical status are:

_____ Phone: _____ Specialty: _____

_____ Phone: _____ Specialty: _____

_____ Phone: _____ Specialty: _____

B. I authorize Unbridled Rehabilitation Services, LLC to communicate with the above listed physician(s) via phone, voicemail, email, and written document regarding my child's medical care.

C. I authorize and request my child's referring physician and Unbridled Rehabilitation Services, LLC to release all information concerning my child's case history, care and treatment while receiving therapy intervention at Unbridled Rehabilitation Services, LLC. These records can be released to representatives of my insurance company or any other third party source of payment responsible for my bill.

D. I understand that I will be responsible for payment of any co-payments or co-insurance required by my insurance company. These payments will be made to Unbridled Rehabilitation Services, LLC at the time of service. I understand failure to keep the account up to date with payments could result in an interruption of services.

Signature _____ Date _____

Client unable to sign because he/she is a minor (*initial*): _____

Payment policies

Billing Service: Therapy services may be covered by your private insurance carrier. As a courtesy to our clients, claims are submitted to your insurance carrier by Unbridled Rehab on your behalf. While we will verify your benefits and discuss them with you at the first visit, it is your responsibility to understand your benefits and that you are ultimately responsible for payment of any balance not paid by your insurance carrier. For any outstanding amounts on your account, you will receive a bill at the beginning of each month for the previous month.

Co-payments, Co-insurances and deductibles: These fees are required to be paid up front at the time of visit. This includes out of pocket fees associated with self-pay accounts.

Self-Pay: The fee schedule for self-pay services will be as listed below.

Initial evaluation visit	$175
60 minute session	$150
45 minute session	$120
30 minute session	$80

Cancellation policy: We require **24 hour notice** for the cancellation of an appointment. Due to the complexity of the team's preparation for each session, less than 24 hour notice negatively impacts both efficiency of sessions that day and the resources available. Unbridled Rehab reserves the right to charge a **$75 cancellation fee** if sufficient notice is not given.

An occurrence of 3 consecutive sessions cancelled without appropriate notice will result in forfeiture of the time slot held to allow for Unbridled Rehab to best serve all clients in need of services.

Medical Expense Accounts: It is important to retain your "Explaination of Benefits" or "Remittance Vouchers" from your insurance companies. These documents can serve as documentation for any out of pocket expenses you wish to submit for reimbursement from your medical spending account. We strongly encourage you to keep records of your cancelled checks and copies of invoices from Unbridled Rehab.

Changes to Insurance Policies: It is the responsibility of the policy holder to notify Unbridled Rehab of any changes to your insurance policy. Many therapy visits require pre-authorization before services are rendered, so it is imperative that we have current insurance information on file at all times. Failure to notify us will result in claim denials and the policy holder may be responsible for payment of these denied therapy visits.

I have read and understand the above terms. I agree to follow this payment agreement.

Client signature _____ Date _____

Signature of Guarantor _____ Date _____
(*if client is under 18*)

Client Information

Client Name: _____ Client's DOB: _____

Parent(s) Name: _____ Home Number: _____

Cell Number: _____ Alt. Number: _____

Address: _____

Email: _____

Preferred method of contact: [ ] Phone call [ ] Email [ ] Text message

How did you hear of us? _____

Referring Physician: _____ Phone Number: _____

Address: _____

Pediatrician (if different from referring): _____

Pediatrician Phone: _____

Insurance Information

Insurance Company: _____ Phone Number: _____

Address: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to Client: _____

Policy Number: _____ Group Number: _____

Employer Name: _____

Employer Address: _____

Guarantor Information

Guarantor for payment: _____ Phone Number (if different from above): _____

Address(if different from above): _____

Signature of Guarantor _____ Date _____

HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as quality assessments or evaluations and physician certifications.

I have been informed by Unbridled Rehabilitation Services, LLC of its Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices.

I understand that Unbridled Rehab has the right to change its Notice of Privacy Practices from time to time, and that I may contact Unbridled Rehab at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Unbridled Rehab restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name _____ DOB: (mm/dd/yy)_____

Signed _____ Date: _____

Patient or Legal Representative for Patient

Legal Representative's Relationship to Patient: _____