350 NW 70 Avenue, Suite A
Plantation, FL 33317
(954) 741-2221
(954) 741-2155
info@PhysicalOne.com
physicalone.com/

Welcome to PhysicalOne™

Thank you for choosing us. We recognize that you have a choice of physical therapy centers and greatly appreciate you for choosing us as your outpatient physical therapy center of choice. The law requires us to request your authorization and consent prior to providing you with care. Enclosed please find the following forms for your review:

- Authorization for Evaluation and Treatment,
- Consent to the Use or Disclosure of Protected Health Information (PHI)
- Patient Financial Responsibility
- Assignment of Insurance Benefits, and
- Cancellation and No Show

Please review these documents.

Please fill in the information in the provided spaces and sign and date each of the documents.

Upon completing the documents, If you completed the forms electronically, simply click Submit. If you completed the pen and paper version of the forms, just hand over the completed documents to a member of our office team.

Please do not hesitate to draw our attention should you have any question. You may do so via email to info@PhysicalOne.com or by calling (954) 741-2221 during regular business hours.

We strive on providing exceptional service and outstanding clinical results and welcome the opportunity to serve you.

Sincerely yours,

The PhysicalOne™ Team

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Authorization for Evaluation and Treatment

I, the undersigned, hereby authorize RehabXperience, LLC DBA PhysicalOne ("PhysicalOne") - its employees, independent contractors, and business associates - to perform physical therapy evaluations and treatments on me (or on the Patient, if I am the Legal Guardian of the patient).

I understand that the therapy may involve risk of injury. I realize that no guarantees have been made to me in relation to the examination, care, or treatment. I understand that I have the right to request an explanation of risks and benefits from services and items provided.

I understand that PhysicalOne is not legally responsible for the acts or omissions of its independent contractors.

Relation to Patient:

- ○ Self
- ○ Legal Guardian

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Consent to the Use and Disclosure of Protected Health Information (PHI)

I, the undersigned, consent to the use and disclosure of my PHI by RehabXperience, LLC DBA PhysicalOne ("PhysicalOne") in accordance with its Notice of Privacy Practices for the purposes of evaluating or providing treatment to me, obtaining payment for the care provided to me, and to conduct health care operations . I understand that evaluation and treatment of me by PhysicalOne may be contingent upon my consent.

My PHI means, in general, health-related information, collected from me and created or received by PhysicalOne, other health care providers, health plans and/or my employer that identifies or can be traceable to me.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations.

I also understand that if I restrict the disclosure of my PHI to insurance companies and other responsible parties, full payment for services rendered will be due at the time of service.

PhysicalOne is not required to agree to the restrictions on the use or disclosure of my PHI that I request. However, if PhysicalOne agrees to a restriction that I request, the restriction is binding on PhysicalOne.

I have the right to revoke this consent, in writing, at any time, except to the extent that PhysicalOne has taken action in reliance on this consent.

I understand I have the right to review PhysicalOne Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes why and how PhysicalOne may use and disclose PHI. It also describes the rights of patients and PhysicalOne's duties with respect to PHI.

_____ A copy of PhysicalOne Notice of Privacy Practices has been provided to me.

PhysicalOne may change its privacy practices from time to time. I may obtain a revised version of the Notice of Privacy Practices by contacting PhysicalOne and requesting that a revised copy be sent to me by regular mail or email or by asking for one at the time of my next appointment.

Relation to Patient:

- ○ Self
- ○ Legal Guardian

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_____ _____

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PhysicalOne™
Physical Therapy & Wellness
Feeling good again

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Patient Financial Responsibility

I understand that not all items and services provided in connection with care patients receive are covered under all insurance policies. I also understand that benefits, coverage policies, and coverage rules differ among insurers and even between different plans of the same insurer.

I further understand that I am ultimately responsible for full payment of charges whether or not I have insurance coverage to help pay medical bills.

I recognize that it is my responsibility to know my insurance's procedures and patient responsibilities. I am aware that my insurer may decline payment and that I may be liable for full payment of the bill if proper procedures are not followed. PhysicalOne explained to me that they may be able to assist me with finding out what financial obligations I may be assuming in connection with my anticipated treatment. They also advised me to call the customer service or member services department of my insurance company prior to my visit(s) to find out what my insurance plan covers and what my financial obligation may be.

I agree to provide PhysicalOne with the details of my insurance it requires. I also agree to notify PhysicalOne immediately on any and all changes to my insurance and to bring with me to every visit a current insurance card and a government issued ID.

I will let PhysicalOne know prior to my visit whether or not my insurance plan requires a referral and/or prior authorization. If prior authorization is required but I have not obtained it the time of my visit, I either may not be seen for my scheduled visit, or will be responsible for full payment of my bill at time of service.

Relation to Patient:

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Assignment of Insurance Benefits

I, the undersigned, agree for the direct payment to RehabXperience, LLC DBA PhysicalOne ("PhysicalOne") of any and all insurance benefits payable to or on behalf of me including, but not limited to, Medicare, commercial insurer, Personal Injury Protection (PIP), or other auto and liability insurance covering me, or any party liable to me.

_____ I further understand that if I receive any insurance payments directly from my insurance carrier or any other liable party covering me for services rendered by PhysicalOne, I will pay over such payments to PhysicalOne within five (5) days.

I understand that if I restrict the disclosure of my Protected Health Information (PHI) to insurance companies and other responsible parties, payment for services rendered will be due at the time of service.

I understand that charges not covered by this assignment including, but not limited to, co-pays and deductibles and due PhysicalOne are payable at the time of service.

Relation to Patient:

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- ○ Legal Guardian

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Cancellation and No Show

I recognize that the effectiveness of treatment and the pace of improvement are significantly affected by the consistency and continuity in treatment.

I also understand that disruption in treatment may adversely affect the outcomes of my therapy.

I understand that I need to make every effort to keep the schedule of treatments RehabXperience, LLC DBA PhysicalOne ("PhysicalOne") communicated to me.

I understand that I am responsible to arrive on time to my scheduled appointments. I further understand that **I am responsible to contact PhysicalOne by 9 pm the day prior to an appointment** I cannot make to give a cancellation notice and reschedule my appointment.

_____ I am aware that PhysicalOne reserves the right to charge me **$25 (Twenty Five Dollars) for each no show or late cancellation** should I fail to meet my responsibility to give a notice as described above. While PhysicalOne does not desire for me to incur additional expenses, this amount will cover some of PhysicalOne resources that are idle as a result of my late cancellation or no-show.

I understand that this fee is my responsibility, will not be billed to my insurance company and is payable upon my following visit.

Following a no-show, PhysicalOne may make a reasonable effort to contact me. Should the efforts by PhysicalOne to maintain my treatment routine fail, PhysicalOne will contact my referring physician and recommend discharge for noncompliance.

Relation to Patient:

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Release Form

Testimonial/Photo/Video

I hereby grant RehabXperience, LLC DBA PhysicalOne ("PhysicalOne") permission to use testimonials of mine, photographs of mine, audio and video recordings of me, quotes or excerpts of quotes from the testimonials or recordings in promotional material and artwork, educational and training material or for similar purpose use in written, typed, print and electronic form, in publications and broadcast, on the internet in emails, on PhysicalOne and other websites (jointly called "Material") without compensation.

I understand that, once published, the Material cannot be retrieved. I agree that my permission is irrevocable. I agree that I may be identified by name and/or title that might accompany the Material. I waive the right to approve the final product. I understand that all the Material, its reproductions, manuscripts, drafts, derivatives, source files in electronic or other form are and shall remain the property of RehabXperience.
I hereby release, acquit, indemnify and forever discharge PhysicalOne and its agents, officers and employees from any and all claims, demands, rights, promises, damages and liabilities arising out of or in connection with the use of the Material including, but not limited to, any claims for invasion of privacy, appropriation of likeness or defamation.

- ○ I am 18 years old or older
- ○ I am younger than 18 years old

I understand that signing this Release Form is optional. The care I receive will not be affected whether or not I sign it.

If individual photographed/recorded is under 18 years old, the following section must be completed:

_____ I have read and I understand this document. I understand and agree that it is binding on me, my child (named above), his/her heirs, assigns and personal representatives. I acknowledge that I am eighteen (18) years old or older and that I am the parent or guardian of the child named above.

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No signature is required here if individual photographed/recorded is 18 years old or older.

Parent/Legal Guardian Full Name	Parent/Legal Guardian Signature	Date

Client Signature	Date