Teletherapy Services, LLC is pleased to be a part of your rehabilitation. We believe that regular communication assists in providing the best service to you. It will be helpful if you complete and bring your **intake form** and **patient responsibility form** to your first visit. If you are unable to print these forms, do not worry, we will provide them at your evaluation.

What to bring to your first visit.

Please bring the following to your initial visit:

- Your **physical therapy referral**.
- Your valid **ID.**
- Your i**nsurance cards**, including supplemental insurance cards.
- Come dressed in comfortable and loose fitting clothes to expose the area being treated.

Patient Responsibilities Form

Please keep up with your visits as scheduled. Your therapy program requires commitment and attending your appointments on a consistent basis is necessary for you to achieve optimal improvement. Your attendance is critical and failure to show up regularly will result in a delayed plan of care.

Please inform us 24 hours in advance if you are unable to attend your visit.

_____ _____

Patient name and signature Date

Financial Policy.

I understand and agree to pay all copays, co-insurance, deductibles or “cash pay” at the time of service.

I understand it is my responsibility to pay all uncovered services within 90 days after my insurance has paid their portion.

_____ _____

Patient name and signature Date

Authorization for Treatment

All procedures will be thoroughly explained to you before they are performed. There are certain inherent risks with Physical Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which can cause an increase in your current level of pain and discomfort or an aggravation of your existing condition.This typically occurs when you first start your sessions. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort.

I read and understand and consent to treatment.

_____ _____

Patient name and signature Date

Notice of Patient Privacy Practices and Rights

We are required by law to maintain the privacy and security of your protected health information. We will not use or share your information other than carrying out treatment, administrative operations related to treatment and payment and communications with your referring provider. We can be provided with a hardcopy of our privacy practices upon request. You can get a copy of your medical record at a reasonable cost based fee.

I authorize Teletherapy Services to release my medical information to insurance companies, physicians, and other pertinent parties that are involved in my claim or care.

I read and understand.

_____ _____

Patient name and signature Date