PREMIER
Therapy Services

Clinic Policies and Consent

Premier Therapy Services reserves the right to release any pertinent medical or other information for the purpose of claims processing. _______ **initial**

Premier Therapy Services will provide treatments and/or procedures that are deemed necessary or advisable for your care. _______ **initial**

Premier Therapy Services will attempt to contact your insurance company prior to your first appointment to verify benefits and eligibility. **However, it remains your responsibility to know your insurance coverage and benefits.** ________ **initial**

- Have you received **ANY** Physical Therapy, or Speech Therapy outside of Premier Bone and Joint since the first of this year? □Yes How Many Visits used? _____ □No

Premier Therapy Services asks that you provide **at least six (6) hours of notice** for cancellations to allow adequate time for other patients to be scheduled. ________ **initial**

Arriving 15 or more minutes late to an appointment may be considered a **"No Show"** and you may be asked to reschedule your appointment. ________ **initial**

After **Two (2) "NO SHOW"** appointments in the course of physical therapy treatment, all subsequent appointments may be cancelled. At which time a **$50 rescheduling fee** may be assessed if you wish to continue your treatment. _______ **initial**

Adhering to scheduled appointments is the patient's responsibility and we ask that you contact Premier Therapy Services directly with schedule issues at (307) 721-8024. _______ **initial**

Patient Name (please print):______________________________ **Patient Signature:**________________________________

Parent or Guardian Signature:___________________________________ **Date:** ___________________________________

Would you like email or text message reminders for your appointments?

□Send me emails Email Address:___________________________________

□Send me text messages Cell Phone:______________________________________

Can we leave you messages on your voicemail or answering machine? Y or N

I give Premier Bone & Joint Centers permission to discuss my medical condition and any billing issues with the following people: (Please indicate if person is Emergency Contact ONLY)

Name: _______________________________________ Phone #: ____________________Relationship: ________________

Emergency Contact only? Y or N

Name: _______________________________________ Phone #: _____________________Relationship: ________________

Emergency Contact only? Y or N

Premier Therapy Services

Acknowledgement of Receipt of Privacy Notice

For patients referred from outside Premier Bone and Joint Centers

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- I have been offered a copy of Premier Bone & Joint Centers' NOTICE OF PRIVACY POLICIES, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice. [ ] (Please initial in box)

Patient Name (please print):______________________________ **Signature:**________________________________

Date: ______________________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship:____________________________________ **Witnessed by:** _______________________________________

<u>If the patient refuses to sign, indicate your attempt to obtain a signature below.</u>

○ Patient refused to sign this Acknowledgement Date & Time: ______________ Employee Name: ________________