

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:** _____

See Reverse Side

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

Please list your Emergency Contacts below:

Name: _____ Phone #: _____ Relationship: _____

Are we allowed to discuss Medical information with this person? Y or N

Name: _____ Phone #: _____ Relationship: _____

Are we allowed to discuss Medical information with this person? Y or N

Premier Therapy Services

Acknowledgement of Receipt of Privacy Notice

For patients referred from outside Premier Bone and Joint Centers

- 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: _____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

Patient refused to sign this Acknowledgement Date & Time: _____ Employee Name: _____