Brostrom Physical Therapy

- Patient Policies Packet -

CLIENT BILL OF RIGHTS

You have the right to, are informed of, and aware of the need:

1) To provide accurate medical history, patient information, and insurance information.
2) To receive services deemed appropriate to your needs.
3) To receive services regardless of race, age, sex, disability, weight, or marital status.
4) To receive information regarding services to be rendered and any charges they may require.
5) To request information regarding insurance coverage, medical records, or ownership of this facility.
6) To be treated with respect, dignity, and courtesy.
7) To have all personal items be treated with respect.
8) To accept or decline services.
9) To notify appropriate personnel about changes in health care providers or insurance information.
10) To follow a medical emergency plan.
11) To maintain a safe environment for other clients and the personnel at Brostrom Physical Therapy.
12) To expect continuity of care from a qualified Physical Therapist who has the knowledge and skill necessary to complete appropriate services.
13) To expect that all records will be kept confidential except as authorized or required by law.
14) To be informed of the name and title of all personnel providing services.
15) To make suggestions, ask questions, or voice grievances/complaints about services rendered.
16) To communicate to the appropriate personnel if there are any changes in health status.
17) To treat other clients and the personnel of Brostrom Physical Therapy with respect, dignity, and courtesy.
18) To inform the appropriate personnel of any desire to change or cancel any service/treatment.
19) To know treatment options and take part in decisions about services that will be rendered. If you are judged incompetent or unable to make decisions, a parent/guardian/family member that you choose can speak for you.
20) To read and copy your own medical record.
21) To ask that the Physical Therapist change your record if it is not correct, relevant, or complete, when necessary.
22) To voice complaints about waiting times, operating hours, and services rendered, adequacy of services or equipment, or actions of a Physical Therapist/personnel.
23) To follow the rules and benefits of health plan coverage.

PRIVACY POLICY/HIPAA

A copy of the *detailed* privacy policy statement is available for your review and is posted within the clinic and on our website. You may request a printed copy of the *detailed* privacy policy statement for your records at any time. Please read through the following *general* disclosure policies carefully; the privacy of your health information is important to us.

Billing Purposes

We will release your personal health information for billing purposes to be reimbursed for services provided. You may request (in writing) to prevent us from doing so, without penalty. If you choose to exercise this right, you will be responsible for your balance, and it will be your responsibility to submit to your insurance carrier for reimbursement.

Legal Duties and Requirements

We will release your personal health information when required to do so by law. We may disclose your personal health information to authorized federal officials where required for lawful intelligence, counterintelligence, and other national security activities. Brostrom Physical Therapy may use or disclose your health information to appropriate authorities if we reasonably believe that you are victim of abuse, neglect, other domestic violence, or the possible victim of other crimes. We may also use or disclose your health information to the extent necessary to avert a serious threat to your health or safety and/or the health or safety of others.

Payment and Healthcare Operations

We may use or disclose your health information to obtain payment for services we render; we may also use or disclose your personal health information in connection with our healthcare operations. Healthcare operations include but are not limited to: quality assessment and improvement activities, evaluation of practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Rights Under HIPAA at Brostrom Physical Therapy

You have the right to look at or get copies of your health information and to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities. You have the right that we place additional restrictions on our use or disclosure of your health information, to request that we communicate with you about your health information by alternative means or locations, and to request that we amend your health information when necessary and appropriate.

CONSENT FORM

During your physical therapy session, it is often necessary to expose or touch the area to be treated. Every effort is made to preserve modesty and keep you comfortable.

Consent for Treatment: I give my consent for treatment by a qualified Physical Therapist and/or Physical Therapist Assistant at Brostrom Physical Therapy to provide physical therapy and rehabilitation services and necessary treatment as prescribed by my physician. I understand that my physician will be kept informed of any services rendered during the current Physical Therapy process. I also understand that the attending Physical Therapist or Physical Therapist Assistant may need visual or physical access to parts of my body that have been indicated as painful, or to practice physical therapy techniques intended towards restoration of my body. I will notify the Physical Therapist, Physical Therapist Assistant, or personnel at Brostrom Physical Therapy if I become uncomfortable with procedures.

Consent of Assignment of Claim: I request that payment of all insurance or authorized benefits be made on my behalf to Brostrom Physical Therapy. I also authorize Brostrom Physical Therapy to release information regarding services rendered for my current condition to my insurance company, or any information the insurance company may request concerning my current illness or injury to continue physical therapy. I understand that if I choose to disallow my insurance company to receive such information, I am responsible for any payments for services rendered. I also understand that I am responsible for any payments that my insurance company does not cover within its contract.

Pelvic Health Cases - Additional Consent for Evaluation and Treatment: I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions. I understand that to evaluate and treat my condition, it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination and/or internal treatment. This is done by observing and/or palpating the perineal region including the vagina and/or rectum to assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback. Treatment to the pelvic region internally may be necessary to fully reach desired results and obtain your personal goals of health and wellness. Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction. I understand I have the option to decline an internal pelvic floor examination and internal treatment and acknowledge that declining the internal exam and treatment limits the therapist's evaluation and ability to treat. I understand that I can change my selected response at any time by completing a new Consent for Evaluation and Treatment. I understand that if I have experienced past physical or emotional trauma related to the pelvic region, it is best to share this information with my treating therapist.

FINANCIAL POLICY

We are committed to the success of your medical treatment and care. Please understand that payment for your medical services is a part of this treatment. For your convenience, we have developed a written statement of our financial policy. It is important to understand that your health insurance benefit is an agreement or contract between you and your insurance company, not you and your provider (Brostrom PT).

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are insured by a plan for which we are considered out-of-network, payment in full is expected at each visit. If you are insured by a plan for which we are in-network with, but you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. We are happy to assist with obtaining insurance benefits but knowing your insurance benefits is ultimately your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-Payments, Deductibles, and Co-Insurance Responsibilities.** Depending on your insurance coverage, you may be subject to co-payments, deductibles, or co-insurance responsibilities for physical therapy services. All estimated patient responsibilities must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances, and deductibles from patients can be considered fraud; please help us in upholding the law by paying your responsibility at each visit.
3. **Handling of Overpayment (Credit) Balances.** We will reconcile the amount you pay for each date of service to the amount your insurance reports as your obligation on their processed claim(s). Per Federal Trade Commission regulations, any overpayment (credit) balances less than or equal to $0.99 will remain on your account for future application. Any overpayment (credit) balance greater than or equal to $1.00 will be refunded to you via check.
4. **Proof of insurance.** All patients must complete our patient information forms before seeing the provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims to your insurance(s) and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.
8. **Payment for Services.** Our office accepts all credit cards, as well as cash or check. Should we need to bill you for services performed, our office will send you a monthly statement. Any outstanding balances are due within 30 days of the statement; all balances that reach 90 days will be subject to collection procedures. For your convenience, we offer payment plans. In addition, we do realize that temporary financial problems may affect timely payment on your account. If such problems do arise, please contact our billing department promptly for assistance in the management of your account.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy, and please let us know if you have any questions or concerns.

CANCELLATION AND NO SHOW POLICY

Your success in physical therapy is important to us. Achieving the best possible outcomes requires consistency, accountability, and active participation in your plan of care.

We understand that unanticipated events may occasionally occur. However, **all scheduled appointments are considered confirmed and reserved specifically for you unless canceled with sufficient notice**. In order to accommodate your schedule - and the schedules of other patients - we require **a minimum of 12 hours' advance notice** to cancel or reschedule any appointment.

Why This Policy Matters: When an appointment is missed or canceled without proper notice, it affects more than just your schedule:

1. **You**, because you miss valuable treatment time critical to your recovery or wellness;
2. **Your therapist**, because the appointment time was reserved exclusively for you; and
3. **Another patient**, who could have received treatment during that time.

****

No Show Appointments: $50.00 per occurrence

A **no-show** occurs when:

- You do not attend your scheduled appointment **without notice**, or
- You arrive **15 minutes or more after your scheduled appointment time** without prior communication.

****

Late Cancellation Appointments: $30.00 per occurrence

A **late cancellation** occurs when:

- You cancel or attempt to reschedule **less than 12 hours** before your scheduled appointment time.

****

Late Arrivals: If you arrive more than 15 minutes late for your appointment, you may be asked to wait until your therapist is available. More than likely, you may need to reschedule your appointment and have a no show recorded for that day.

Important Reminders:

- **Please do NOT cancel** because you feel worse or believe treatment is not helping. Temporary increases in pain or symptoms are common during rehabilitation. Your therapist needs to assess and adjust your care accordingly.
- **Please do NOT cancel** because you feel better. Attending visits while you are improving allows your therapist to safely progress your program and prepare you for discharge.
- **Missed appointment and cancellation fees are not covered by insurance or other payers** and will be billed directly to you. Payment is due upon receipt of statement.

By scheduling an appointment with our clinic, you acknowledge and agree that **appointments are considered confirmed unless canceled with proper notice** and that you are responsible for any applicable fees outlined above.

If you have questions about this policy or need assistance with scheduling, please contact our front desk. We appreciate your cooperation and commitment to your care.