Patient: ______________________________________ Date: ______/________/________

INFORMED CONSENT FOR OCCUPATIONAL / PHYSICAL THERAPY PROVIDED AT MEMPHIS HAND CENTER, INC dba SOUTHERN HAND CENTERS

The patient has the right to informed participation decisions involving his / her healthcare. This shall be based on a clear concise explanation of his / her condition and of all proposed treatment procedures. All possible risks and / or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his / her attending therapist. The patient shall not be subjected to any procedure without his / her voluntary, competent, and understanding consent or consent of their legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall so be informed. The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. After reading the above, I hereby consent to receive occupational / physical therapy at MEMPHIS HAND CENTER, INC dba SOUTHERN HAND CENTERS on the date below and terminating when determined by myself, my physician, or my therapist. I have read this information and understand its content.

PAYMENT POLICY

The Fee Schedule of MEMPHIS HAND CENTER, INC dba SOUTHERN HAND CENTERS is based on usual and customary fees for the type of service provided. Generally, your insurance policy will cover some portion of the services provided**. Please Note: There is no guarantee of payment. Should your insurance carrier deny payment, the totaled uncovered balance will be transferred to personal pay and will be your responsibility.** You are responsible for any deductible, copays, coinsurance or ineligible charges. **Copays/coinsurance are due at the time of service and you are responsible for payment of all medical supplies.**

Insurance payments that are sent directly to you shall be presented to MEMPHIS HAND CENTER, INC dba SOUTHERN HAND CENTERS along with the explanation of benefits and any other information you received with payment. Monthly statements will be sent to your home informing you of your balance due and advising you of the status of your account. **If for any reason an amount for which I am responsible should become delinquent, I agree to pay interest at a rate of 8% per annum.** I also agree to pay for all applicable collection fees of 35% and should the collection agency be forced to litigate, the fees increase to 50%, not including court costs. I have read this information and understand its content and that I am ultimately responsible for payment of my account.

HIPPA POLICY

I give consent to MEMPHIS HAND CENTER, INC dba SOUTHERN HAND CENTERS to disclose information from my medical record to my insurance carrier for the purpose of obtaining benefit information to benefits payable; or my attending physician or other healthcare professionals directly involved with my care and / or to my attorney for legal purposes. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I understand that confidentiality of my medical records are protected under state and federal law and that this release gives consent to MEMPHIS HAND CENTER, INC dba SOUTHERN HAND CENTERS only and not to any party to whom such information is released.

NONDISCRIMINATION POLICY

MEMPHIS HAND CENTER, INC dba SOUTHERN HAND CENTERS does not in any way discriminate in the provision of services. We have a full non-discrimination policy available for your review posted in the facility and a personal copy can be obtained upon request.

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to the practitioner named above. I attest that my insurance coverage and personal financial responsibilities regarding occupational / physical therapy treatments have been fully explained to me. I have read, and agree to abide by the above PAYMENT POLICY, AUTHORIZATION TO RELEASE INFORMATION and ASSIGNMENT OF BENEFITS for occupational / physical therapy provided at MEMPHIS HAND CENTER, INC dba SOUTHERN HAND CENTERS

THERAPY COMPLIANCE POLICY

Effective therapy requires consistency in treatment. The plan of care determined by your therapist and/or physician is specifically designed for you and your condition. Compliance with this plan of care is for your benefit and essential for optimal recovery. Ideally, all patients will be discharged when their course of treatment has been completed and their highest level of function has been restored. However, excessive no shows or cancellations can significantly limit your level of recovery and occupies appointment times that could be used for other patients. **Administrative discharge will occur if any patient misses 3 consecutive therapy appointments or 5 therapy appointments total**. In order to resume treatment, you must see your physician and/or present a new prescription for therapy. A notice will be sent to your physician, case manager (if applicable), and you regarding administrative discharge from therapy secondary to noncompliance with your plan of care. I have read and understand the THERAPY COMPLIANCE POLICY.

Signature of Patient or Guardian:

____ Date _______/_______/_________

I give permission to communicate via: phone _______________ ◻ txt and/ or ◻ voicemail

I give permission to communicate via: ◻ email _____________________________________