Bal Therapy, LLC

Informed Consent to Treat

Patient Name: _____

I hereby request and consent to the performance of Therapy services and other procedures within the scope of the practice of skilled Physical, Occupational and/or Speech Therapy on me (or on the patient named above, for whom I am legally responsible) by the therapists who work with me while employed by, working or associated with, or serving as back-up for Bal Therapy, LLC.

Methods of Treatment

I understand that methods of treatment may include, but are not limited to: a complete assessment and evaluation, Range of Motion activities, manual , free weights, yoga, plyometrics, functional training, cognitive training, speech and swallowing training, True Stretch, mobility exercises, balance exercises, nautilus type equipment, MobilityStep, steps, stairs, cardiovascular equipment, sleds, a rack, adjustable benches, slide boards, adjustable dumbbells, resistance tubing and band, ab rollers, etc. I understand that, as with all forms of medical treatment, there are benefits and risks involved with fitness and personal wellness training.

I understand that results are not guaranteed.

Patient Privacy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: I) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, II) Obtain payment from third-party payers and, III) Conduct normal healthcare operations such as quality assessments and physician certifications. I understand that the clinical and administrative staff may review my patient records, but all my records will be kept confidential and will not be released without my written consent. I understand that I may request in writing that Bal Therapy, LLC restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Bal Therapy, LLC is not required to agree to my requested restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Bal Therapy, LLC has taken action relying on this consent.

Patient Media Release

I, the undersigned, understand that Bal Therapy may take photos or videos in the normal course of treatment to aid patient care. I hereby grant permission to the staff of Bal Therapy, LLC to use images, likenesses, audio or any other data (heretofore referred to as “Media”) obtained through my treatment for instructional, educational or research purposes. This includes all photos, videos, audio recordings, charts, graphs, analysis or any other data obtained in the course of my treatment. The Media may be used in any professional manner that is deemed necessary and I understand that the Media belongs to Bal Therapy, LLC and I will not receive any compensation or payment in connection to their use. I understand that I can request the Media not be used for marketing purposes via written request to Bal Therapy. I assume the risks involved in releasing this information and release Bal Therapy, LLC and its employees and contractors from any and all liability that could arise from use of this Media.

Informed Consent to Treatment

I, the undersigned, hereby expressly and affirmatively state that I wish to participate in therapy training. I realize that my participation in this activity involves risks of injury including but not limited to: cardiovascular and orthopedic type injuries, serious disabling injuries, and even the possibility of death. I also recognize that there are many other risks of injury that may arise due to my participation in this activity, and that it is not possible to specifically list each and every individual injury risk. However, knowing the material risks and appreciating, understanding, and anticipating that other injuries and even death are a possibility, I hereby expressly assume all of the delineated risks which could occur by reason of my participation. I have had an opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I subjectively understand the risks of my participation in this activity, and I voluntarily choose to participate, assuming all risks due to my participation.

Financial Responsibilities

I understand that Medicare and certain other insurances cover skilled Physical, Occupational, and Speech Therapy and determine the reimbursement based on multiple factors, including but not limited to: the Patient's need for skilled therapy, expected progress and continued room for improvement, a signed order from a doctor or qualifying medical practitioner, a reasonable and timely expectation of meeting goals to prove progress. I agree that medicare will not cover repetitive or redundant activities and never covers actions that are considered "Maintenance" or "Wellness", despite the skills needed to provide such services. I understand that services deemed Wellness and Fitness is a pay-for-service agreement and is not covered under Medicare or any other insurance. I recognize that the services provided are directed towards wellness and fitness training, and not affiliated with physical, occupational or speech therapy. I understand that Bal Therapy will notify me with due time to help distinguish the difference between covered therapy and private pay wellness and fitness activities.

I hereby agree to pay the full allowed amount of services rendered and agree to provide a credit card to be automatically charged by Bal Therapy, LLC in the event that payment is not made at time of service. I recognize that treatment times can vary day to day and agree to pay along the terms described below on page 3. I agree to allow Bal Therapy to charge my credit card and recognize that there is a 20% processing fee for charge-backs, canceled payments or payments that are outstanding for more than 60 days.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Effective Date/ Start of Care: _____

_____	_____	_____
PATIENT SIGNATURE	**Co-signer**	**Relationship**
Date:	**Date:**	

A. Notifier: Bal Therapy LLC
B. Patient Name: _____ C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D.___ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the **D.___** below

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
● Physical Therapy ● Occupational Therapy ● Speech Therapy	1. Yearly CAP has been reached 2. Lack of a Physician's referral 3. No Medicare allowed Rx on file 4. Therapist believes this treatment to be medically unnecessary or comfort care. 5. The diagnosis/treatment techniques used are not covered by Medicare. 6. You have instructed us to bill another insurance company or opt to pay cash for these services.	● Evaluation: $250 ● Follow up Therapy Treatments: ○ Half Session: $78 ○ Full Session: $148

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.___** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
□ **OPTION 1.** I want the **D.**_____listed above and I want Medicare to pay for it. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less copays or deductibles. □ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed □ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about- us/accessibility-nondiscrimination-notice.