PT Onsite

978-572-0402
ptonsite.com

CONSENT

CONSENT TO TREATMENT: I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

Signature of Patient or Legal Guardian: ____Date:___/___/_____

ATTENDANCE

PTONSITE provide reserved time slots for each patient to minimize your waiting and assure quality treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last-minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of all patients.

We asked that a scheduled appointment be cancelled AT LEAST 24 HOURS IN ADVANCE. No showing for an appointment without notification is obviously more impactful to your and others opportunity for care. Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

ATTENDANCE POLICY: I acknowledge that I read and understand the Attendance Policy and agree to abide by its terms and conditions.

Signature of Patient or Legal Guardian: ____Date:___/___/_____

DIRECT ACCESS

Please refer to the following site for state Direct Access Information - https://getpt.org/physical-therapy-direct-access-laws-state/

DIRECT ACCESS LAW POLICY I confirm that I disclosed or affirmatively confirmed in writing the identity of my primary care provider, health care provider of record, licensed health care professional of record, or health care practitioner to my rehabilitation provider, and I acknowledge that I read and understand the Direct Access Law Policy in the state I am receiving rehabilitation therapy and agree to abide by its terms and conditions, and I consent to receive rehabilitation therapy and any supplementary services that are deemed medically necessary or appropriate by my therapist without a referral from an eligible practitioner.

Signature of Patient or Legal Guardian: ____Date:___/___/_____

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INSURANCE

I understand that PTOnsite , PLLC is a fee-for-service clinic, does not participate with insurance companies and will not bill my insurance. I agree to pay for my evaluation and treatments at the time of service, by charge card unless other mutually agreed upon arrangements have been made. I understand NH is a direct access state and a physician's referral is not required to make an appointment. I understand it is the responsibility of patients/clients seeking care from PTOnsite, PLLC and interested in insurance reimbursement to ascertain their outpatient physical therapy benefits prior to receiving treatment. PTOnsite, PLLC will provide an itemized receipt, upon request, that can be submitted to the patient's/client's insurance company for reimbursement pending available benefits. I understand it is my responsibility to submit to my insurance. If further documentation is requested, these will be provided. I understand that PTOnsite, PLLC does not guarantee I will receive any reimbursement from my insurance company, even if I submit a receipt and/or documentation provided by PTOnsite, PLLC. I also acknowledge that some services rendered by PTOnsite, PLLC fall under the category of wellness interventions outside of medical necessity and may not be considered covered services under the category of physical therapy by my insurance company, despite being recognized as the scope of practice of a licensed physical therapist. I understand and agree that PTOnsite, PLLC does not accept auto accident liens.

Signature of Patient or Legal Guardian: ____Date:___/___/_____