INFORMED CONSENT FOR THERAPY: [ ] PHYSICAL [ ] SPEECH [ ] OCCUPATIONAL

I, the undersigned hereby authorize the administration of such treatment and procedures for myself, or named dependent, as is therapeutically considered necessary. I further understand that physical, speech, and/or occupational therapy services shall generally be delivered through the utilization of customary and usual techniques and has been used to treat various neurological, orthopedic, and medical problems. In addition, I understand that circumstances may arise that therapy services need to be provided via telehealth. Telehealth therapy is a therapy Evaluation or Treatment service provided using a platform through the internet via video & audio features connecting me to a therapy service provider in real time. I desire this therapy service to be performed. If I wish to opt out of Telehealth services, I must identify that at the bottom of this form. I certify that the foregoing authorized treatment and/or procedures have been explained to me and I understand the reason(s) for it, the advantages and possible complications, if any, and alternate modes of treatment. No guarantee of results has been given to me. I understand that I am free to discontinue treatment at any time or upon my physician's order.

I also hereby authorize the provider of services to release any information regarding this treatment or subsequent treatment relative to this injury or illness to my physician and family and/or others for the purpose of completing insurance forms which I may submit or which may be submitted by others in connection with this case.

As applicable, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or to the Professional Standards Review Organization any information needed for this or a related Medicare claim. If a Medicare claim, I request that payment of authorized benefits be made on my behalf.

☐ I prefer to opt out of telehealth therapy

I further understand that I am responsible for payment as indicated below:

[ ] Private Pay	Family/patient is responsible for 100% of payment
[ ] Commercial Insurance Plans (includes Med Replacement and Managed Care Part A)	Insurance covers the treatment cost while authorized for services. Deductibles and co-pays may apply. Consult your plan for details.
[ ] Medicare Part A	Medicare covers 100% of the treatment cost for 20 days. After 20 days the family and/or patient is responsible for the co-pay unless a co-insurance covers those charges.
[ ] Medicare Part B / Private Pay (Includes Insurance B, Managed Care Part B/Pvt pay)	Medicare Part B covers 80% of the treatment cost after the yearly deductible is met. The family and/or patient is responsible for the yearly deductible and the remaining 20%, unless a co-insurance covers those charges.
[ ] Medicare Part B / Public Aid (Includes Insurance B, Managed Care Part B/PA)	Medicare B & PA covers 100% of the treatment . The family and/or patient is not responsible for payment.
[ ] Public Aide only (no ins benefits) (includes Managed Care PA)	No charges will be incurred to the patient and/or family.

Facility: ____ Date: _________________________

Patient (Print Name): ____

Patient, Guardian or Responsible
Party Signature: ____Relationship to Pt: ___________

Witness to Signature: ____