INFORMED CONSENT: Physical therapy services include the examination, evaluation, and testing of individuals to diagnose mechanical, physiological or developmental impairment, functional limitation, disability or other health and/or movement disorders, to determine a rehabilitation prognosis and plan of therapeutic intervention, and to assess the ongoing effects of the interventions.

I understand that I am voluntarily engaging in physical therapy services and that no health care provider can guarantee the results of treatment as every individual reacts in a different way. Though physical therapy treatments are usually beneficial and rarely cause any problems, I understand that, like many other forms of health care, there are some risks. I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of an existing injury or condition, during the testing process. I understand this discomfort is usually temporary and if I have concerns or it does subside in 24 hours I will contact PT2U LLC for guidance.

Initial: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that at my request PT2U LLC will provide me with a copy of the clinic's Notice of Privacy Practices. I understand that PT2U LLC will use and disclose health information about me as necessary to facilitate my treatment, as allowed and restricted under current health information privacy laws. I acknowledge and allow PT2U LLC to use my protected health information to determine my eligibility for insurance coverage, submit claims and bills among other related information to my insurance company, and to transfer that information to others who may be responsible to pay for my health care.

Initial: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT: I hereby give lifetime authorization for payment of insurance benefits to PT2U LLC for any services rendered. I authorize PT2U LLC to release all information necessary to secure payment of benefits. I will provide a copy of my current insurance card. I understand that PT2U LLC will check coverage and bill my insurance as a courtesy, but I am ultimately responsible for understanding my insurance coverage and financially responsible for all charges whether or not they are covered by insurance, including applicable copayments, coinsurance, and/or deductible charges. I understand that PT2U LLC cannot guarantee insurance coverage of services but will put forth best effort to obtain accurate information through the relevant insurance portals. If my insurance writes the PT reimbursement check to me I will notify and deliver those funds to PT2U LLC within 7 days, for coverage of my services.

I will notify PT2U LLC of any insurance changes before my next appointment. I understand that I have the right to refuse any services before they are rendered if I think they are non-covered services or not payable by my insurance.

COPAYMENTS & COINSURANCE: I understand that all **copays & estimated coinsurance are due at time of service**. I understand that if I have a percentage coinsurance I will be billed for an estimated amount based on average charges and after return of the insurance claim and payment PT2U LLC will adjust my account accordingly to charge or credit the difference.
CASH PAY / SELF PAY: I understand that if I elect for a set time of service charge it will be due at time of service and will not be able to be submitted to insurance.

Initial: _____

Printed Name: _____
Signature: _____ Date: _____

ACCOUNT BALANCE: I understand that **if I have a balance on my account it will be due at time of service** unless other payment options have been agreed upon. All balances will accrue a $25/month fee, or 20% of the account balance, whichever is higher. All costs accrued in pursuit of collecting an overdue balance will be the responsibility of the patient. If I have a balance on my account I will receive a monthly statement that is due for payment upon receipt. All balances are considered late if unpaid within 14 days of notice, unless other arrangements in writing are made with PT2U LLC. All outstanding accounts will be turned over to a collection agency after three unpaid statements unless alternative arrangements are made in writing with PT2U LLC.

Initial: _____

MEDICARE: PT2U LLC is a participating provider with Medicare. Medicare will pay 80% of what they allow, minus the annual deductible. The 2025 annual deductible is $257. If this has not been met, I understand I will be responsible for payment of the deductible at time of service, and once the deductible is met I will be responsible for the 20% co-insurance if not covered by a secondary insurance. I authorize any holder of medical or other information regarding my care to release such information to the Social Security Administration effective from this signed date. I agree to and understand if my secondary insurance does not remit payment within 120 days I will pay the remaining balance.

Initial: _____

CANCELLATION & NO SHOW POLICY: I understand that last minute cancellations negatively impact my therapy and PT2U LLC's ability to service the community. I agree that if I fail to notify PT2U LLC of a cancellation or reschedule at least 24 hours before my appointment it will be recorded as a “same day” cancellation and may be subject to a $60 fee that is not reimbursable by insurance. I understand if PT2U shows up for a scheduled appointment and I am not home, and have not previously canceled my appointment, I will be subject to a $100 fee that is not reimbursable by insurance. I understand if I have more than three same day cancellations within a 4 month period I may be dismissed from care. I understand that if I do not return scheduling calls regarding missed appointments that I may be dismissed from care earlier than those three qualifying visits.

Initial: _____

RETURNED CHECKS: I understand that personal checks returned for non-sufficient funds will be charged a fee of $40. I understand after a returned check all balances must be handled by cash, credit card, or money order.

Initial: _____

NECESSITY OF CONSISTENCY: I understand that for physical therapy to work I need to be consistent with my program and communicate clearly with my physical therapist questions, concerns, and difficulties completing it. I understand that large gaps in my scheduling, without prior conversation with my therapist, may end in my dismissal.

Initial: _____

Printed Name: _____

Signature: _____ Date: _____

VOICE TRANSCRIPTION: To improve the accuracy and efficiency of my medical records, PT2U LLC may use electronic dictation, audio recording, voice recognition, and artificial intelligence assisted transcription tools, including third party BAA HIPAA-compliant vendors after my visits.

PT2U LLC requires any third party vendor that receives or processes my health information to sign a Business Associate Agreement and to implement privacy and security measures designed to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable Oregon law.

I understand **after transcription the original recording will be deleted**, and these tools are used only for permitted health care operations, including treatment, documentation, and care coordination, as allowed by federal and state privacy laws. I understand that these tools do not replace the professional judgment of my clinician. My clinician remains responsible for and manually reviews, edits, and approves all clinical documentation.

I understand that I may ask questions at any time about this technology and how my information is used. If I wish to limit or withdraw my consent to the use of audio recording and transcription tools, I will notify PT2U LLC before or at my first visit. I acknowledge that such a limitation may affect the availability, timing, or method of documentation and communication, but PT2U LLC will continue to provide care as clinically appropriate and as allowed by law and payer requirements.

I understand that Oregon law generally requires that all parties be informed when in person conversations are recorded. By signing this form, I acknowledge that I have been informed that audio recording and transcription technology may be used as described above, and I consent to such recording and use for my care and related health care operations.

Initial: _____

Printed Name: _____

Signature: _____ Date: _____