2103 Reedale Ave
Augusta, GA 30906
(706) 814-6887

Patient Consent & Agreement

Consent for Treatment & Provision of Services: I have a condition requiring therapy intervention, wellness & health promotion, or performance program participation, and consent to the delivery of such care and/or services. In order to improve my physical condition in regards to pain, range of motion, strength or another type of physical impairment, I consent to enter ProActive Rehabilitation & Wellness programs for evaluation and treatment. I request and authorize the licensed staff of ProActive Rehabilitation & Wellness, LLC to render treatment, and to perform appropriate procedures that my referring provider may deem reasonable and necessary for my diagnosis. I understand that my clinical care and treatment may be provided by a licensed clinician, either a licensed therapist or assistant. I am aware that there are certain risks involved with any therapy, wellness & health promotion, and/or performance program. Every effort is made to minimize my risk by continuous assessment of my condition throughout my participation in the program. I will inform my therapist or clinician of any changes in my medical condition, or medications, as they may necessitate change in my individualized program. I will stop any procedure or activity and inform my therapist or clinician of any symptoms of pain, fatigue, shortness of breath, dizziness or nausea that may develop during my treatment or session. _____ (initials).

Privacy Notice Acknowledgement: As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby acknowledge that I have had the opportunity to review a copy of ProActive Rehabilitation & Wellness LLC's "Notice of Privacy Practices". I understand that I am responsible to read this Notice and notify Proactive Rehabilitation & Wellness, LLC, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. ProActive Rehabilitation & Wellness, LLC has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times. I am aware that ProActive Rehabilitation & Wellness, LLC has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains. ProActive Rehabilitation & Wellness, LLC will provide me with a copy of its most recent Notice upon my request. _____ (initials).

Requirement to Provide Proof of Current Insurance and Obtain Referral: I understand that it is my responsibility to provide ProActive Rehabilitation & Wellness with a copy of my current insurance card(s) and to obtain a referral from my Primary Care Physician's

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office (if required by my insurance or by state law). If I do not have insurance, I will be considered a Self-Pay patient and I am financially responsible for the total amount of the services provided. I will notify ProActive Rehabilitation & Wellness immediately upon any changes in my insurance. _____(initials).

Insurance Waiver: I understand that if I do not have a copy of a current insurance card and valid referral, if required, ProActive Rehabilitation is not obligated to see me, but if I still wish to be seen, I can be seen as a "Self-Pay" patient. I agree that neither Proactive Rehabilitation & Wellness nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance. _____(initials).

Payment: Co-payment is due on each day services are rendered. We accept cash, money order or check. There is a $25.00 charge for all returned checks to cover administrative costs. When an account has received two returned checks, it will automatically be placed on a "cash" only status. _____(initials).

Assignment of Benefits: I hereby authorize and assign all payments and/or insurance benefits for therapy services rendered to the patient, directly to ProActive Rehabilitation & Wellness, LLC. I hereby authorize ProActive Rehabilitation & Wellness to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan. _____(initials).

Appointments/Cancellations: We typically see patients by appointment. Please call ahead if you think you will be late. We appreciate 24 hours notification of cancellations. You may leave a message on voicemail if you are calling after hours. If there are consistent lapses in scheduled attendance, you will incur a $50 for each No Showed visit or late cancellation to cover administrative costs of rescheduling. This charge will be assessed to your account. _____(initials).

Attire: For access to particular body parts being treated, loose fitting clothing is recommended. If your evaluation includes a diagnosis that involves an assessment of the pelvis and/or pelvic floor muscles, This may require you to change clothing and wear a gown. An example of this might be evaluation and treatment for the diagnosis of lymphedema or urinary incontinence. _____(initials).

Adult Supervision: Those under the age of 16 receiving treatment at our facility must be accompanied by a parent or legal guardian during each service appointment. _____(initials).

ProActive
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Other Information: I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records, not covered by my insurance plan. _____(initials).

By signing this agreement, I acknowledge that I have read, understand and agree to the above terms and conditions

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____