PATIENT ACKNOWLEDGMENT FORM

Please Read thoroughly and initial/sign

_____ I consent to an EVALUATION AND TREATMENT by the Bodylogic staff. Our intention is to provide the very best care to you and will do everything in our power to help you. The staff will explain any risks and benefits to procedures and techniques and I understand that I have the right to refuse any procedure.

_____The filing of insurance claims is a courtesy that we extend to our patients, as long as we participate in that insurance. We participate with most major carriers. YOU WILL BE RESPONSIBLE FOR ANY CHARGES NOT REIMBURSED BY YOUR INSURANCE COMPANY. We will have our billing associate call regarding your coverage to see if you will need to pay down your deductible; or if you have met your out of pocket maximum and what your co-payment is for PT services, if any. This is not a guarantee of your benefits, so if you have any questions, please contact your insurance company directly.

_____Co-payments, deductible or self payments are due at the time of service, unless different arrangements have been discussed and agreed upon with the rendering therapist. Furthermore, patients are responsible for returned check fees that are charged to Bodylogic.

_____I hereby assign to Bodylogic Integrative Physical Therapy, Inc all insurance payments for medical services rendered to myself or my dependents.

_____I authorize the RELEASE OF INFORMATION acquired in the course of my evaluation and treatment including but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer-(workers compensation), primary care or specialty physician, referring MD, other third party payers and/or the following persons (spouse, family member, chiropractor, massage therapist,
etc)_____

_____I authorize Bodylogic to contact me by phone, e-mail, and /or text messages regarding my treatment and scheduled appointments. Our scheduling platform will message you with an e-mail and/ or text message at the time of scheduling and 24 hours prior to your appointment(s).

_____Because of high demand for our services, if for any reason you need to cancel your appointment, please do your best to call us at 828-424-9290 within 24 hours. This gives us the opportunity to offer other patients the hour slot that was originally scheduled for you.

_____Your health, the health of our staff and families, and the heath of our other patients (often elderly) are important to us. We ask that if you are feeling ill, coughing excessively or have had a fever in the past 2 days, please reschedule your appointment.

_____Your healthcare data including your personal information is important to us to protect. So, please consider reading our policy located on the back of this form. You are welcome to a copy if you would like. I acknowledge that I received Bodylogic's NOTICE OF PRIVACY PRACTICES.

I _____fully agree to the terms stated above.
Patient signature/ or legal representative

Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how the health data about you may be used and shared and how you can get access to this data.

I. How we may use and share health data about you:

a. Treatment – To give you medical treatment or other types of health services
b. Payment – To bill you or a third party for payment for services provided to you
c. Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a. To you
b. As required by a federal, state, or local law
c. If child abuse or neglect is suspected
d. Public health risks (for public activities to prevent and control the spread of disease)
e. Lawsuits and disputes (in response to a court or administrative order)
f. Law enforcement (to help law enforcement officials respond to criminal activities)
g. Coroners, medical examiners and funeral directors
h. Organ or tissue donation facilities if you are an organ donor
i. To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories
b. Persons involved in your care or payment for your care – We may share your health data with your family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to health data we keep about you:

a. Right to inspect your health record and to receive a copy upon request
b. Right to amend information in your health record you believe is inaccurate or incomplete
c. Right to know to whom we have disclosed your health information
d. Right to ask for limits on the health information data we give out about you
e. Right to receive communication from us about your health information in alternate ways
f. Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge received the NOTICE OF PRIVACY PRACTICES of this office.