



PATIENT ACKNOWLEDGMENT FORM

\_\_\_\_\_ 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 many carriers. ONCE YOUR VISITS HAVE BEEN PROCESSED, YOU WILL BE RESPONSIBLE FOR ANY CHARGES NOT REIMBURSED BY YOUR INSURANCE COMPANY. If you owe money to Bodylogic, you will be billed by our billing company (Medical Billing Company of Maudlin SC).

\_\_\_\_\_We try to call or use the internet to look up your benefits. Keep in mind that the information we receive MAY NOT BE CORRECT-we have NO control over this. **So we urge you to know your own benefits by contracting 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):

\_\_\_\_\_During your treatment, you and your therapist may decide to utilize a treatment that may have some risks associated with it. These may include dry needling, heat, cold therapy, micro-tens etc. Your therapist will explain the risks and benefits and you ultimately will decide if you will authorize the treatment. You, of course have the right to refuse. I hereby authorize my therapist to perform treatments that we both decide are relevant.

\_\_\_\_\_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). You are in control of what you receive. If you do not want to be texted, don't include your mobile phone number. If you don't want to be e-mailed, don't include your e-mail when using our scheduling application. However, you will need to choose one or the other.

\_\_\_\_\_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. If you do not show and/or cancel without 24 hours notice, you will be billed \$70.00.

\_\_\_\_\_Your health, the health of our staff and families, and the health 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. In a pandemic situation, please note that we will be wearing masks, taking temperatures, using air purifiers and will be sanitizing between patient care. We expect that you will be wearing a mask as well.

\_\_\_\_\_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: \_\_\_\_\_

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