Altruistic
THERAPY SERVICES

CONSENT FORM for Treatment, Payment and Healthcare Operations

Welcome and thank you for choosing Altruistic Therapy Services, LLC. We are committed to providing you with the highest quality care in an efficient, timely, and effective manner. If you have any questions, please feel free to discuss them with our staff.

1. ***Consent for Treatment:*** *I hereby authorize the attending therapist /practitioner at Altruistic Therapy Services, LLC to prescribe, administer, and perform such examinations, and treatment as necessary or advisable in the diagnosis and treatment of my condition. I understand that the practice of therapy is not an exact science and acknowledge that no guarantees have been or will be made regarding the results of examinations or treatments in this clinic.*
2. ***Legal Relationship between Altruistic Therapy Services, LLC and therapists:*** *Some of the professional therapists performing services for Altruistic Therapy Services, LLC are independent contractors and are not agents or employees of Altruistic Therapy Services, LLC. Independent contractors are responsible for their own actions and for identifying themselves to you as independent contractors, and Altruistic Therapy Services, LLC shall not be liable for the acts or omissions of any such independent contractors.*
3. ***Disclaimer of Guarantees:*** *I acknowledge that the practice of a therapy discipline is not an exact science and that treatment may involve the risk of adverse results and injury, I acknowledge that no guarantees have been made as to the results of therapeutic treatment (herein called "Treatments") that may be undertaken by Altruistic Therapy Services, LLC. While routinely performing without incidence, there may be material risk associated with each of these treatments. I understand that it is not possible to list every treatment or every risk for every treatment. I also understand that various professional therapists may have differing opinions as to what constitutes material risk associated with specific treatments.*
4. ***Assignment of Benefits:*** *In consideration of any services rendered to me by Altruistic Therapy Services, LLC, I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to Altruistic Therapy Services, LLC. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursement made under my Medicare plan which pertains to any services provided to me by Altruistic Therapy Services, LLC.*
5. ***Authorization to Release Information:*** *I authorize Altruistic therapy Services, LLC to release and disclose any Private Health Information about me that pertains to any and all medical care, tests, treatment, or advice that was rendered to me by the therapist and/or staff of Altruistic Therapy Services, LLC to any physicians, practitioners, insurance companies, third party payers, authorized agents, claims review organizations, support staff or facility involved in my plan of care or transfer of care and/or Medicare in order to process a claim and/or payment on my behalf. Please list additional persons, relationship and phone number:*

   _____

   _____

Altruistic
THERAPY SERVICES

6. ***HIPPA Notice of Privacy Practices:*** *I acknowledge that a copy of the Altruistic Therapy Services, LLC HIPPA Notice of Privacy Practices will be made available to me at my request, and that I have read, or had the opportunity to read if I so chose, and understand the Notice.* ***Please note that email is not HIPAA compliant. If you choose to communicate with Altruistic Therapy Services, LLC via email, please do so at your own risk. We encourage you to send any medical documentation via fax: 866-886-6628, mail or in person.***
7. ***Payment Agreement:*** *I understand that by providing a valid and current insurance card prior to services being rendered, Altruistic Therapy Services, LLC will file a claim to my insurance company but that does not guarantee payment which ultimately I am responsible for. I hereby accept and assume financial responsibility for any covered or non-covered services rendered to me and will be responsible for any services that are unpaid as a result of not providing Altruistic Therapy Services, LLC with a valid referral. If there are any questions, problems, or delays regarding my coverage and or benefits, I understand that it is my responsibility to solve these issues with my insurance carrier and the billing office administrator. Deductibles, co-payments, and payment for non-covered services will be due at the time of service.*

Please sign below if you have read, understand and agree to the above five statements.

*Signature of Patient or Responsible Person:*_____

Printed Name: _____ *Date:* _____