Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

Consent for Treatment

CONSENT FOR CARE AND TREATMENT:
I hereby agree and give my consent to Engage PT, OT, SLP PLLC to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

TELEHEALTH:
This means that through an interactive video connection, I will be able to consult with the above named provider about my health and wellness concerns. I understand there are potential risks with this technology: The video connection may not work or it may stop working during the consultation. The video picture or information transmitted may not be clear enough to be useful for the consultation. The benefits of a telehealth consultation are: I do not need to travel to the consult location. I have access to a specialist through this consultation. I also understand other individuals may need to use the Heno telehealth platform and that they will take reasonable steps to maintain confidentiality of the information obtained. I have read this document and understand the risk and benefits of the telehealth consultation and have had my questions regarding the procedure explained and I hereby consent to participate in telehealth sessions under the conditions described in this document.

ACCESS TO AND RELEASE OF HEALTH INFORMATION:
I understand that Engage may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Engage's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Engage's Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information. I acknowledge that I have received Engage's Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information. By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____
Patient Name

_____ _____

Patient or Guardian Signature Date

Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

Payment and Insurance Policy
FINANCIAL POLICY

It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. We ask that you make copayments, co-insurance and deductibles at the time of each visit. Your balance **must** be paid in full on or before the 1st day of the following month and any unpaid balance will be considered past due on the 5th of the month.

PATIENT'S RESPONSIBILTY

It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status. _____(Initial)

It is the patient's responsibility to:
- Understand their insurance policy, and to ask questions when they don't.
- Obtain a referral indicating medical necessity for physical therapy services.
- Pay co-pays, co-insurances, and/or deductibles at the time of service.
- Promptly pay any patient financial responsibility indicated by their insurance carrier.
- Contact their insurance carrier when claims have not been paid.
- Obtain updated referrals or prescriptions for therapy when there has been more than a 30-day lapse in care or when their referral is dated more than 60 days previous to their 1st visit.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Engage Therapy & Wellness to furnish information to my insurance carrier(s) concerning treatment and I hereby assign all payment for services rendered
to Engage Therapy & Wellness. _____(Initial)

MEDICARE PATIENTS – (please provide card)
Have you had any PT this year provided in your home or in another outpatient clinic? ____Yes _____ No _____# of visits

Do you currently have Medicare home services? _____ Yes _____ No

SELF PAY PATIENTS: For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid at the time of service. _____ (Initial)

VOLUNTARY TERMINATION OF TREATMENT:
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.
_____(Initial)

Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

I have read the above information and I UNDERSTAND MY RESPONSBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____

Patient /Parent/Guardian Name (Print Name)

_____

Patient/Parent/Guardian Signature

_____

Date

Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

Commitment to Therapy

Late, No-Show, Cancellation and Re-scheduling Policies

Engage Therapy and Wellness requires 24-hour notice to cancel or reschedule your appointment.

We understand life happens and you may need to miss a scheduled appointment. However, please be considerate and provide adequate notice if you cannot make it. When you late cancel, we are unable to give that appointment to someone else who needs our assistance.

**Reminder emails are provided as a courtesy to you. These reminders are computer generated and may not be error free, but these instances should be very few, if at all. Ultimately it is your responsibility to know when your appointments are scheduled. A no show or late cancel fee will still be applied if you say you did not get a reminder.

Patients who late cancel or no show will be charged a fee for the missed appointment. Therapists are paid by insurance for time spent treating patients; insurance does not pay for missed appointments or late arrivals.

Illnesses and emergencies are addressed on an individual basis. Please contact our office manager if you have any questions.

We understand during the winter in Syracuse there will be winter storms. We stay open unless there is a weather-related travel ban. If you do not feel comfortable driving due to weather related conditions, teletherapy is always an option. Please discuss this with your therapist so you can easily switch your appointment.

Fees

If you late cancel or no show, the fee will be collected at your next appointment. If no visit is scheduled, a bill will be mailed to you.

- Late cancellations – $50 per incident
- No shows – $100 per incident

Descriptions

- Late Cancellation- Appointment is cancelled within 24 hours of scheduled appointment.
- No Show- Patient cancels within 2 hours of appointment or does not show up for scheduled appointment.

Attendance Policy

Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

Your success in therapy depends on your attendance and accountability. If you miss too many appointments or continually show up late, you will be removed from the therapy schedule until you are able to commit to the treatment process.

Reasons for removal from the schedule include:

- Excessive late cancellations
- No shows (after 2nd incident)
- Repeated late arrivals (more than 5 minutes late)

Cancelling? Please call the office at least 24 hours in advance (*Monday appts need to be cancelled by Friday at the time of the appointment on Monday, unless due to illness*). DO NOT email your physical therapist to change or cancel an appointment. The office manager and client coordinator handle all scheduling.

[NOTE: Workman's Compensation Cases only] If your case is a Workman's Compensation case, Engage Therapy and Wellness is not allowed to charge you for appointments that you miss or no-show for or did not cancel within the 24-hour notice. However, you do understand that Engage Therapy and Wellness will notify your workman's compensation carrier and/or case manager to alert them of appointments you miss or no-show for or have cancelled with or without a 24-hour notice and this may jeopardize acceptance of your claim and lead to denial.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

The above information has been explained to me. I understand that in the event of a late cancellation or no show, I authorize Engage Therapy and Wellness to charge the amount of $50 for a late cancellation and $100 for a no show.

_____
Patient /Parent/Guardian Name (Print Name)

_____

Patient/Parent/Guardian Signature

_____
Date

Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

Demographic Information and Patient Medical History

Patient Full Name (as it appears on your insurance card) _____

Preferred Name/Nickname _____

How did you hear about Engage Therapy and Wellness? (Please be specific, so we can say "Thank you")

Physician___ Former client_____ Gym____ Internet (google/web)_____ Other_____

Referring Physician:_____

Date of next visit with referring physician:_____

Primary Care Physician: _____ Primary Care Phone # _____

Patient Medical History

Type of Injury or condition: _____ Date of injury/onset: _____

(If applicable) Type of surgery/procedure: _____

Date of Surgery: _____

Please describe your physical limitation because of this condition, injury, or surgery:

_____

_____

_____

Please describe any activities or movement at that aggravate your symptoms:

_____

_____

_____

Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

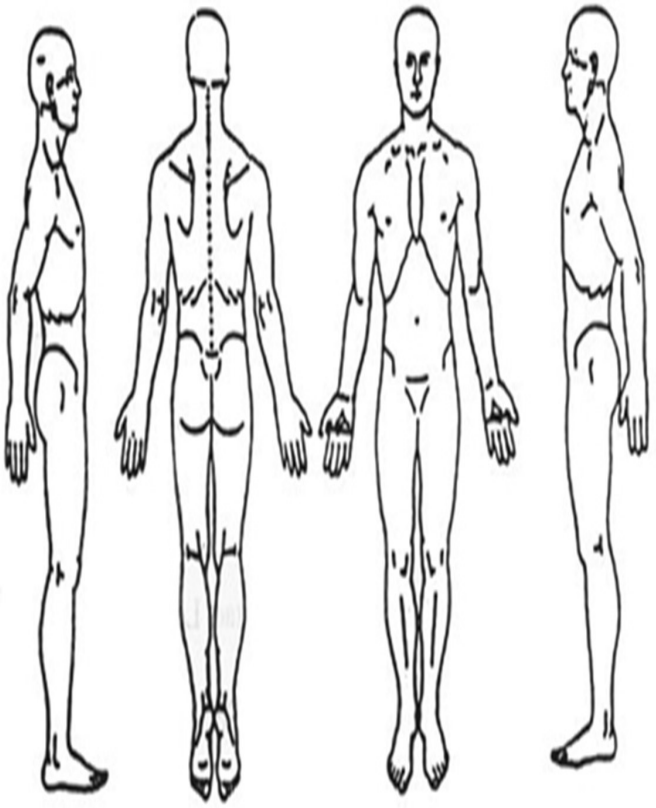
Please describe any treatments, movements or self- care that decrease your symptoms:

Have you had any of the following diagnostic test in relating to this injury?

all that apply

☐X-Ray ☐MRI ☐CT Scan ☐Doppler ☐Ultrasound ☐Other

Please mark all the areas of your symptom(s):



Which of the following describes your pain:

(mark all that apply) ☐Sharp ☐Achy ☐Burning

☐Tingling ☐Numbness ☐ Other:

Please rate your pain:

(0= none, 5=moderate, 10= Severe)

At present: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

Are you currently taking ANY medications?

☐ YES ☐ NO

Please list ALL medication/dosages:

_____

Fall History: Is your injury the result of a fall? ☐ Yes ☐ No

Have you fallen twice or more in the past year? ☐ Yes ☐ No

Dates of falls: _____

Health Habits and Lifestyle:

Do you eat a well-balanced diet? ☐Yes ☐No Do you drink water regularly? ☐Yes ☐No # of glasses each day:

Do you smoke? ☐Yes ☐No Daily amount: _____ For how long? _____

Do you drink alcohol? ☐Yes ☐No #/day? _____ Days/week? _____

Do you exercise regularly? ☐Yes ☐No How often? _____ Type / program? _____

Do you have any hobbies/leisure activities: ☐Yes ☐No

Type: _____

Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

Height _____ Weight _____

Medical History: have you been diagnosed with any of the following conditions:

Allergies	Y	N	Diabetes	Y	N	Metal implants	Y	N
Anemia	Y	N	Dizziness/ringing in ears/vertigo	Y	N	Multiple Sclerosis	Y	N
Anxiety	Y	N	Emphysema/Chronic Bronchitis	Y	N	Neurological disorder	Y	N
Arthritis	Y	N	Fibromyalgia/Chronic Fatigue	Y	N	Numbness/tingling	Y	N
Asthma	Y	N	Fractures	Y	N	Osteoporosis/Osteopenia	Y	N
Bladder/Bowel problems	Y	N	Gastrointestinal Problems	Y	N	Pain Syndromes/CRPS	Y	N
Cancer	Y	N	Gallbladder problems	Y	N	Parkinson's	Y	N
Cardiac Disease/Conditions	Y	N	Headache/Migraines	Y	N	Pneumonia	Y	N
Cardiac pacemaker/	Y	N	Hearing Loss	Y	N	Reflux	Y	N
Defibrillator	Y	N	Hepatitis	Y	N	Seizures	Y	N
Circulation problems	Y	N	Hernia	Y	N	Speech/language problems	Y	N
Currently pregnant	Y	N	High blood pressure	Y	N	Strokes	Y	N
Depression	Y	N	Incontinence	Y	N	Swallowing Problem	Y	N
			Kidney problems	Y	N	Thyroid problems	Y	N
						Vision problems	Y	N

Please describe in detail any diagnosis marked "Y":

_____

Have you experienced any illness not listed here? ☐ Yes ☐ No If yes, please explain:_____

_____

Food or drug allergies: _____

Treatment History:

Have you been treated for this condition before? By whom? _____

Was it helpful? ☐Yes ☐No Please explain:

_____

_____

Engage Therapy and Wellness
3175 East Genesee Street Suite 5
Syracuse NY 13224
P: 315-810-2423

What are your goals for therapy?

_____

_____

Please list any important dates (such as return to work, school, sport, etc. coming up that you want to be ready to participate):

_____

_____

Is there anything else you would like to include or ask your therapist?

_____

_____

_____
Patient Name

_____ _____

Patient or Guardian Signature Date