THERAPY BENEFIT SHEET

PATIENT NAME _____

PRIMARY INSURANCE COMPANY _____

IN NETWORK _____ OUT OF NETWORK _____

DEDUCTIBLE _____ DEDUCTIBLE REM _____

MAX OUT OF POCKET _____ AMOUNT REM OUT OF POCKET _____

MAX VISITS _____ VISITS BASED ON MEDICAL NECESSITY

(FILL IN THE MAX VISITS OR HIGHLIGHT THE MEDICAL NECESSITY CHOICE)

COPAY FOR MULTIPLE THERAPY ON SINGLE DAY _____

THERAPY PAID TO DATE _____ COPAY _____ COINSURANCE _____

AUTHORIZATION REQUIRED EVALUATION: YES _____ NO _____

AUTHORIZATION REQUIRED FOLLOW UP: YES _____ NO _____

_____

As a courtesy, we have contacted your insurance company to verify your insurance coverage and benefits. The information verified may be subject to an error on the part of you or your insurance company. According to your insurance company, this in not a guarantee of payment. **I acknowledge that I am the patient (or legal guardian of the patient) listed above, and the information contained on this form has been explained to me.**

GLOSSARY

Coinsurance: The % of costs of a covered health care service you pay after you've paid your deductible.
Copay: A fixed amount you pay for a covered health care service after you've paid your deductible.
Deductible: The amount you pay for covered health care services before your insurance plan starts to pay.
OUT OF POCKET MAXIMUM: The most you must pay for covered services in a plan year. After you spend this amount on deductibles, co-payments, and coinsurance for care and services, your health plan pays 100% of the costs of covered benefits.
Medical Necessity: Services that are: provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and except for clinical trials that are described within the policy, not for experimental, investigational or cosmetic.

Patient Name **Patient or Guardian Signature** **Date**

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 Therapy & Wellness 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. 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

COMMITMENT TO THERAPY

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

LATE, NO-SHOW, CANCELLATION & RESCHEDULING POLICES

We understand life happens and you may need to miss a scheduled appointment. However, please be considerate and provide adequate notice. When you late cancel, we are unable to give that appointment to someone else who needs our assistance. ***Reminder** emails are computer generated and may not be error free, but these instances should be few. Ultimately it is your responsibility to know when your appointments are scheduled. A no show or late cancel fee will apply if 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 there will be storms. **We stay open unless there is a weather-related travel ban.** If you do not feel comfortable driving due to weather related conditions, telehealth is an option. Please discuss this with your therapist so you can switch your appointment.

Fees

If you are more then 10 minutes late, cancel with less than 24 hour notice, or no show, the fee will be collected same day or at your next appointment. If you do not have a follow up visit scheduled, a bill will be mailed to you.

Appts on a Monday must be cancelled by 2 PM the Friday prior otherwise a late cancellation fee will apply

More than 10 minutes late- $50 and visit cancelled 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 does not show up for scheduled appointment. Must contact within 24 business hours or all future appointments will be cancelled.

Attendance Policy

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 10 minutes late)*

Canceling? Please call the office at least 24 hours in advance. **DO NOT email your Physical Therapist to change or cancel an appointment. The Office Manager and Client Coordinators handle all scheduling.**

NOTE: Workman's Compensation Cases only: Engage Therapy & Wellness is not allowed to charge for no show or missed appointments that you did not cancel within the required 24-hour notice. However, you do understand that Engage Therapy & Wellness will notify your workman's compensation carrier and/or case manager to alert them of your disregard for medical therapy services by missed or no-show appointments which 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.

Patient Name	**Patient or Guardian Signature**	**Date**

PATIENT MEDICAL HISTORY

DEMOGRAPHIC INFORMATION - PAGE 1 OF 3

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: _____ **Primary Care Physician**: _____

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 make your symptoms worse:

_____

_____

_____

_____

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

_____

_____

_____

_____

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

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

PATIENT MEDICAL HISTORY

DEMOGRAPHIC INFORMATION - PAGE 2 OF 3

Height _____ Weight _____ Food or drug allergies: _____

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

Was it helpful? Yes _____ No _____ Please explain: _____

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? _____

Medical History

Have you been diagnosed with any of the following conditions? IF YES, PLEASE CHECK:

Allergies _____
Anemia _____
Anxiety _____
Arthritis _____
Asthma _____
Bladder/Bowel Problem _____
Cancer _____
Cardiac Disease/Condition _____
Cardiac Pacemaker _____
Defibrillator _____
Circulation Problem _____
Currently Pregnant _____
Depression _____
Diabetes _____
Dizziness/ringing in ears/Vertigo _____
Emphysema/Chronic Bronchitis _____
Fibromyalgia/Chronic Fatigue _____
Fractures _____
Gastrointestinal Problem _____
Gallbadder Problem _____
Headache/Migraines _____
Hearing Loss _____
Hepatitis _____
Hernia _____
High Blood Pressure _____
Incontinence _____
Kidney Problem _____
Metal Implants _____
Multiple Sclerosis _____
Neurological Disorder _____
Numbness/Tingling _____
Osteoporosis/Osteopenia _____
Pain Syndromes/CRPS _____
Parkinson's Disease _____
Pneumonia _____
Reflux _____
Seizures _____
Speech/Language Problem _____
Strokes _____
Swallowing Problem _____
Thyroid Problem _____
Vision Problem _____

Please describe in detail any diagnosis checked above:

_____

_____

_____

_____

PATIENT MEDICAL HISTORY

DEMOGRAPHIC INFORMATION - PAGE 3 OF 3

Please list ALL medications/dosages:

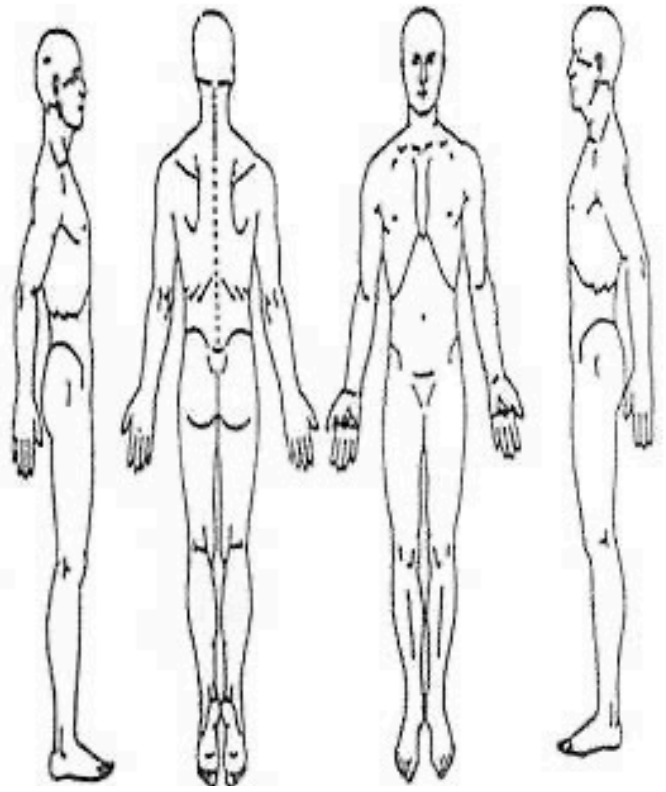
1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Additional medication information:

_____

Have you had any of the following diagnostic tests in relating to this injury? Please mark all the areas of your symptom(s):

X-Ray _____ **MRI** _____ **CT Scan** _____
Doppler _____ **Ultrasound** _____ **Other** _____



Which of the following describes your pain: (mark all that apply):

Tingling _____ Sharp _____ Achy _____
Burning _____ 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

Patient Name **Patient or Guardian Signature** **Date**

FINANCIAL POLICY

PAYMENT and INSURANCE 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 RESPONSIBILITY: 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, Occupational and/or Speech 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
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**)

I HAVE READ THE ABOVE INFORMATION ANDI UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

Patient Name	**Patient or Guardian Signature**	**Date**

HIPAA RELEASE FORM

HIPAA RELEASE - PAGE 1 OF 2

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I, _____, give my permission for ENGAGE THERAPY & WELLNESS to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the below healthcare organization permission to: (check as appropriate)

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

☐ Disclose my complete health record except for the following information

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Section III - Reason for Disclosure

Please detail the reason why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

Section IV - Who can Receive My Health Information

I give authorization for the health information detailed in Section II of this document to be shared with the following individual(s) or organization(s)

Name: _____ **Organization**: _____

Address: _____ **FAX #** _____

I understand that the person(s)/organizations(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

HIPAA RELEASE FORM

HIPAA RELEASE - PAGE 2 of 2

Section V

This authorization to share my health information is valid. **Check as appropriate:**

☐ **a)** From _____ To _____

☐ **b)** All past, present, and future periods _____

☐ **c)** The date of the signature in Section VI until the following event: _____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to **ENGAGE THERAPY & WELLNESS**

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give my further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in Section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits. I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI - Signature

Signature: _____ Date: _____

PRINT YOUR NAME _____

If this form is being completed by a person with legal authority to act an individuals behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____
Signature of person completing this form: _____
Describe below how this person has legal authority to sign this form:

_____

_____

Summary Of Policies

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

Therapy Benefit Sheet (TBS) : I have received and signed by Therapy Benefit Sheet for 2026 _____(Initial)

Attendance Policy: I acknowledge I have been notified of the 2026 update _____(Initial)

- Updates for 2026:
  - Monday appt cancellations must be completed on **Friday by 2 PM** otherwise a late cancellation fee will apply
- Reminder:
  - If you are **10 or more minutes** late your appointment will be cancelled and a $50 fee applies
  - We stay open unless there is a weather-related travel ban
  - **Late cancellation** - $50 fee
  - **No show**- $100 fee
  - Excessive late cancellations, Now shows (after 2nd incident), and repeated late arrivals may lead to removal from the schedule

Financial Policy: I acknowledge I am aware of the financial policy _____(Initial)

- Reminder:
  - Charges for treatment are due at the time the service is provided
  - It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claim status

HIPPA: I acknowledge I am aware of the HIPPA policy _____(Initial)

- Reminder:
  - In order to share health information the party of interest must be granted permission via the HIPPA form and completed in full for records and information to be shared
  - You are able to request a HIPPA form at any point during and after your care
  - Your referring provider is granted access to these records when the referral is received

*Please note that this is a brief summary of policies and does not include all details. Please notify staff if you would like to review the full policy. All policies were provided and signed for in detail at the beginning of your care.

_____. _____

Patient Signature **Date.** **Therapist Signature** **Date**

Therapy Agreement

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

We want you to achieve your goals and get the most out of therapy; this requires regular, consistent attendance. For this reason, we have enacted a contract between you ("The Patient"), and Engage Therapy and Wellness to ensure that we can help you achieve your goals. Unlike many medications, therapy is meant to be a highly concentrated dose over a shorter period to improve the challenges you are facing. However, much like a doctor prescribes a medication, your therapist will prescribe activities and exercises to improve your overall health. Therapy is most effective when you make your appointments and follow your home exercise program.

Three goals for therapy:

1. _____
   _____
2. _____
   _____
3. _____
   _____

We strive to provide one-on-one service; however, this requires that you keep your appointments and give us at least 24 hours' notice to reschedule you. As such we have a strict 24-hour cancellation policy and late attendance policy. You will be charged $50 if you are more than 10 minutes late and the appointment will be cancelled. You will also be charged $50 for each cancellation with less than 24 hours notice and a $100 charge for any no show appointments. For any No-Show appointments you must contact us within 24 business hours or all future appointments will be cancelled.

I agree to perform my therapy exercises at home to the best of my ability to meet my therapy goals.

I agree to ask questions if I do not understand why I'm doing my exercises or what my exercise activities are achieving.

I understand that based on my initial evaluation my plan of care will be _____days per week for _____ weeks. I also understand this may be revised based on my success in progress at my re-evaluation.

_____. _____

Patient Signature Date. Therapist Signature Date

Alternate therapist(s) in case your primary therapist is out of office: _____

Preferred Contact Method: _____

Waitlist Preferences:

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					
Evening					