



Office Policies

Please check off each acknowledgement below. These acknowledgements help us coordinate care, bill correctly, and communicate with you about your therapy plan.

CONSENT AND FINANCIAL AGREEMENT

☐ Consent for Treatment

I understand that I have presented myself to Bridge Physical Therapy for evaluation and/or treatment. I authorize Bridge Physical Therapy and its clinicians to provide appropriate physical therapy evaluation, treatment, and related services. I understand that rehabilitation services may involve bodily contact, exercise instruction, manual therapy, and direct contact as clinically appropriate. I acknowledge that outcomes cannot be guaranteed.

☐ Treatment of Minors

If I am the parent or legal guardian of a minor receiving treatment, I understand that I have been advised to remain on the premises during treatment unless otherwise directed by the clinic. If not applicable, I may enter N/A.

☐ Information Sharing for Payment and Operations

I authorize Bridge Physical Therapy and its affiliated care partners to share information necessary with insurers, payers, government programs, utilization review entities, billing representatives, clearinghouses, data vendors, and other parties involved in treatment, payment, and health care operations, consistent with applicable law.

☐ Assignment of Benefits

I authorize applicable insurance benefits to be paid directly to the provider or facility for services rendered through Bridge Physical Therapy. I authorize release of information necessary to secure payment of benefits. If I have multiple insurance policies, I understand that I am responsible for coordinating primary and secondary coverage when required.

☐ Payment at Time of Service

I understand that patient responsibility amounts, including copays, deductibles, coinsurance, and non-covered services, are due at the time of service unless other written arrangements have been approved.

☐ Financial Responsibility

I understand that I am financially responsible for charges not paid by insurance, including denials, benefit errors, policy exclusions, service caps, or non-covered services. I understand that balances may need to be resolved before additional non-urgent services are scheduled.

☐ Collections

I understand that unpaid balances may be referred to a collection agency after reasonable billing efforts. In the event of default, I may be responsible for reasonable collection costs as allowed by applicable law and the clinic financial policy.



Communication + Privacy

Please complete the communication, privacy, and disclosure authorizations below.

COMMUNICATION AUTHORIZATION

☐ Communication Authorization

I authorize Bridge Physical Therapy to communicate with me by U.S. mail, telephone, text message, email, and/or patient portal for medical, scheduling, administrative, and financial purposes. I understand that communication preferences may be updated in writing.

Preferred Phone

Preferred Email

PATIENT RIGHTS AND PRIVACY

☐ Acknowledgement of Patient Rights

I acknowledge that I have been provided the opportunity to read the Notice of Patient Rights and have had any questions answered by this office.

☐ Notice of Privacy Practices

I acknowledge that Bridge Physical Therapy has provided me the opportunity to view and read the Notice of Privacy Practices.

☐ Disclosure of Protected Health Information

I authorize disclosure of my protected health information to the family members, relatives, close friends, or other persons identified below, to the extent directly related to that person's involvement in my care or payment for care.



Authorized Disclosure

List any family members, close friends, or other persons who may receive information related to your care or payment for care.

AUTHORIZED PERSONS FOR PHI (PROTECTED HEALTH INFORMATION) DISCLOSURE

Name

Relationship

Phone

Name

Relationship

Phone

☐ I object to disclosure of my protected health information to family members, relatives, close friends, or other persons.

Patient / Legal Guardian Signature

Date

Printed Name