



Orange City Physical Therapy
719 8th street SE
PO Box #24
Orange City, IA 51041
www.orangecitypt.com

Important Notices for Patients Receiving Physical Therapy and/or Occupational Therapy

General Notices

Certain restrictions may apply with your insurance company for physical and/or occupational therapy services. We advise you to contact your insurance company by using the toll-free number on the back of your insurance card to verify coverage. Some questions you may want to ask:

- Does my insurance cover physical and/or occupational therapy?
- Are there any restrictions on where I can receive these services?
- Does the therapy need to be pre-authorized?
- My treatment may call for "Iontophoresis" is this a covered under my Insurance Policy?

If I cannot make my appointment, it is my responsibility to call and cancel. I understand that if I do not call to cancel, I risk being removed from any further scheduled appointments that I have made.

If you're insurance company has any questions they may call Amy @ 712-546-1718.

I have read the above questions and I understand it is my responsibility to know my insurance policy and that I will check with my insurance should I have any questions or concerns.

Signature of Patient or Legal Guardian

Date



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Patient Consent Form - HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to Orange City Physical Therapy or by reviewing the current copy in our waiting room binder.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature

Date

Witness

Optional: Please restrict access to my personal health information (PHI) from:

Name

Address

Phone Number

Name

Address

Phone Number