Dove Physical Therapy, LLC
250 Commerce Street ● 3rd Floor, Suite 7 ● Montgomery, AL 36104
Phone: 334.549.4231 ● Fax: 334.649.1010 ● Alt. Fax: 334.676.1652 ● DovePhysicalTherapy@gmail.com ● www.DovePT.com

Patient Registration Form

Personal & Demographic Information

Name Last: _____First: _____MI: _____

Home Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

SSN: _____Birth Date: _____ Sex: ____

Employer **(If you are under 18 years of age, list your Parents'/Guardians' employers here. If unemployed, list your Spouse's/Responsible party's employer.)**

Company Name: _____
Address: _____
Work Phone: _____
Company Name: _____
Address: _____
Work Phone: _____

Insurance Information

Primary Insurance Company Name: _____
Subscriber ID# or Policy# and Group#: _____
Secondary Insurance Company Name: _____
Subscriber ID# or Policy# and Group#: _____

Referring Physician

Name: _____
Address: _____
Phone: _____ Fax: _____
Diagnosis or description of problem: _____
Date of Onset: _____
Reason for Physical Therapy: _____
_____
Previous serious illness or injury: _____
_____

Contact Person in Case of Emergency

Name: _____
Address: _____
Phone: _____ Relationship: _____
How did you hear about Dove Physical Therapy? _____
_____

_____ _____
Patient/Guarantor Signature **Date**

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Medical History

1. Age* _____ **2. Please describe reason for treatment:** _____

3. At present, how would you rate your health? □ Excellent □ Very Good □ Good □ Fair □ Poor

4. Place an "X" next to any problems listed below you are currently experiencing:

____ Coughing Spells	____ Weight Changes	____ Flu Symptoms (past 2 weeks)	____ Work/family problems
____ Excessive Thirst	____ Headaches	____ Trouble with Ears/Hearing	____ Problems getting up from
____ Trouble with Stomach	____ Anxiety	____ Balance Problems*	chair without using arms
____ Fatigue	____ Numbness	____ Bowel/Bladder Problems	____ Suicidal Thoughts
____ Aching Muscles/Sprains	____ Shortness of Breath	____ Trouble with Eyes/Vision	
____ Trouble Sleeping at Night	____ Depression	____ Chest Pain/Discomfort	

5. Place and "X" next to any of the problems listed below that relate to your personal history:

____ Anemia	____ Hepatitis	____ Chemical Dependency	____ Hospitalizations:
____ Asthma	____ Kidney Disease/Problems	(i.e., Alcoholism)	_____
____ Arthritis*	____ High Blood Pressure	____ Osteoporosis	_____
____ Cancer	____ Multiple Sclerosis*	____ Falls in last 6 months*	_____
____ Diabetes	____ Thyroid Problems	____ Infectious Diseases:	_____
____ Autoimmune Disorder	____ Epilepsy	_____	_____
____ Heart Problems	____ Stroke*	_____	_____

6. Have you had surgery/surgeries? □ Yes □ No **If yes, please list:** _____

7. Do you smoke cigarettes? □ Yes □ No **If yes, how many packs per day?** _____

8. Do you drink alcohol? □ Yes □ No **If yes, how many drinks per day?** _____ **Per Week?** _____

9. Do you exercise regularly? □ Yes □ No **How many hours per week?** _____

10. Do you drink caffeinated beverages? □ Yes □ No **How many cups/glasses per week?** _____

11. Are you allergic to any medications, foods, or substances? □ Yes □ No **(If yes, please list below.)**

12. List all medications you are currently taking

Medication (prescription and/or over-the-counter) and Herbs	Reason for Taking

13. Please list services/tests you have had for this injury: _____

14. What are your goals while in this program? _____

15. Primary physician _____ **Phone** _____

16. Another physician_____ **Phone** _____

_____ _____
Patient Signature **Date**

_____ _____
DovePT Representative Signature **Date**

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Rehabilitation New Patient Guidelines

Carefully read the form. Then, sign and date. If you have any questions or concerns, please do not hesitate to ask the administrator or therapist.

Our goal is to provide you with excellent service and care to ensure that your maximum potential is achieved. Your active participation is essential to the success of your therapy.

We will do our best to:

- Begin scheduled sessions within ten to fifteen (10-15) minutes of your appointment time.
- Provide make-up sessions whenever scheduling allows.
- Provide at least one-hour notice of cancellations or provide a different therapist for that session.
- Plan time during therapy sessions to answer questions and discuss progress.

We will ask you to:

- Arrive on time for all sessions (if you are late, we may not be able to extend your session).
- Sign in/check in at the reception desk upon arrival.
- **Provide at least 24-hour notice for all cancellations. Giving us a 24-hour notice may allow us to schedule another patient in that appointment slot. Your consideration of others seeking treatment is greatly appreciated. (*Please carefully read appointment cancellation/no-show policy on next page.*)**
- Be available during therapy sessions to discuss questions and progress with your clinician.
- Follow recommended home activities and exercise programs.
- Only use equipment when supervised by your therapist.
- Please wear appropriate attire for therapy sessions. ***(Warning: Therapeutic oils, lotions, or gel products may be used.)***
- Have family or friends wait in our lobby unless requested by the therapist to participate in the therapy session. Children are not allowed in treatment areas and must be properly supervised in the lobby. Please wait quietly and respect the privacy of others while waiting in the lobby. Thank you for your understanding and consideration of others.

Our attendance policy is as follows:

- Chronic tardiness may be cause for discontinuation of services.
- More than two cancellations in one month may be cause for discontinuation of services.
- A "no-show" is considered when a patient has missed a scheduled appointment without calling to cancel or reschedule the appointment at least 24 hours in advance.
- If the patient has not contacted the physical therapy department within 5 business days after a no-show appointment, the patient will automatically have service discontinued.
  Note: All remaining appointments will be canceled.
- Three no-show appointments will be automatic grounds for discontinuation of services. Any scheduled appointments will be canceled and your physician will be notified of the reason for discontinuation. **(*Please carefully read appointment cancellation/no-show policy on next page.*)**

_____ _____

Patient/Guarantor Signature **Date**

_____ _____

Dove PT Representative **Date**

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APPOINTMENT CANCELLATION/NO-SHOW POLICY

Thank you for trusting your physical therapy care to Dove Physical Therapy, LLC (DovePT). When you schedule an appointment with DovePT we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please read our *Appointment Cancellation/No-Show Policy below*:

- Effective June 25, 2018, any established patient who fails to show or fails to cancel/reschedule an appointment and has not contacted our office by phone, e-mail, or text message with at least a 24-hour notice will be considered a ***No-Show*** and charged a ***$25.00 no-show fee***.
- Any established patient who fails to show or fails to cancel/reschedule an appointment without a 24-hour notice a ***second*** time will be charged a ***$50.00 no-show fee***.
- If a ***third*** no-show and/or failure to cancel/reschedule an appointment should occur without a 24-hour notice, the patient may be **dismissed** from DovePT.
- The fee is charged to the patient, ***not the insurance company***, and is ***due at the time of the patient's next office visit.***
- As a courtesy, when time allows, we send text reminders or make phone call reminders for appointments. If you do not receive an appointment reminder by phone or text messaging, the *Appointment Cancellation/No-Show Policy* remains in effect. All appointments are confirmed on the initial evaluation.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact us as soon as possible. You may contact DovePT 24 hours a day, 7 days a week at the numbers or email below. If it is after regular business hours or the weekend, you may leave a message or email. Messages left at either location are acceptable. Please add DovePT's contact information to your cell phone as a quick reference to use.

Office Phone	(334) 549-4231	Text message or voicemail
Alt. Phone	TBA	Only voicemail
Email	DovePhysicalTherapy@gmail.com phinkleOA@dovept.com	Email message

I have read DovePT's *Appointment Cancellation/No-Show Policy.* By signing, I fully understand and agree to its terms.

_____ _____
Printed Name **Relationship to Patient**

_____ _____
Signature (Parent/Legal Guardian) **Date**

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Waiver and Release of Liability

Carefully read the form and sign and date. If you have any questions or concerns, please do not hesitate to ask the administrator.

In agreeing to receive care provided by Dove Physical Therapy, LLC ("Dove Physical Therapy" and/or "DovePT") and to use the facilities located at 250 Commerce Street, Montgomery, AL 36104. I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Dove Physical Therapy, LLC (DovePT) and the physical therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of DovePT, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the owners, representatives, or employees of DovePT or by any other person on the property of 250 Commerce Street, Montgomery, AL 36104. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Dove Physical Therapy, LLC and their owners, representatives, employees, assigns and/or heirs from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the owners, representatives, or employees of Dove Physical Therapy, LLC.

I HAVE READ THE ABOVE WAIVER AND RELEASE. BY SIGNING IT, I AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE DOVE PHYSICAL THERAPY, LLC FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

_____
Patient/Guarantor Name (Print)

_____
Patient/Guarantor Signature

_____
Patient Date of Birth (D.O.B.)

_____
Date

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INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient,

Physical therapy involves the use of many different types of physical evaluation and treatment. At Dove Physical Therapy, LLC (DovePT), we use a variety of procedures and modalities to help us try to improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain, injury, or even aggravation to previously existing conditions. You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session. Manual therapy and therapeutic exercises are an integral part of most physical therapy treatment plans; thus, both have inherent physical risks associated with it. If you have any questions regarding the type of manual therapy the physical therapists is performing, the exercise(s) you are performing, and any specific risks associated with manual therapy and your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Dove Physical Therapy, LLC, and all of my questions have been answered to my satisfaction. I understand the risks associated with the therapeutic treatment plan/program of DovePT as outlined to me, and I wish to proceed.

_____

Patient/Guarantor Name (Print)

_____

Patient/Guarantor Signature

_____

Date

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PAYMENT INFORMATION AND CONTRACT

Thank you for choosing Dove Physical Therapy, LLC (*DovePT, we, our, us*) as your physical therapy provider. Before we begin services, please sign below indicating you have read, understood, and agreed to the following payment policies. You (the Patient) agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

In-Network Policy

Dove Physical Therapy, LLC is a fee-for-service clinic. Dove Physical Therapy, LLC is "in-network" with *Blue Cross Blue Shield of Alabama*, *United Healthcare*, *TRICARE*, *Aetna*, *Viva Health*, *Medicare* and *Veterans Affairs (VA) Community Care Network (CCN)*. Patient co-payment or co-insurance is due at the time of service, and the office will submit your insurance claim as a *courtesy* to you. Please note that we are not responsible for nor will we be an involved party in health insurance coverage/plan issue(s), conflict(s), and/or dispute(s) that may arise between you and your health insurance provider. Please understand that we are ***NOT*** an involved party in your health insurance contract. It is your responsibility to know your health plan and resolve any health insurance coverage/plan issue(s), conflict(s), and/or dispute(s) with your insurance provider. In any cases where your insurance will not cover the charges for services rendered because your coverage and benefits have exalted, are expired, or do not cover physical therapy, you, the patient, will still be held accountable for the full payment of any services rendered. We accept Apple Pay, Google Pay, Cash App Pay and Cards (credit and debit cards from Visa, MasterCard, American Express, Discover), Flex Spending Cards, and debit/credit cards (*a convenience fee will be applied*).

Out-of-Network Policy

Dove Physical Therapy, LLC is a fee-for-service clinic. This means that Dove Physical Therapy, LLC is not "in-network" with all private health insurers and plans. Payment is due at the time of service, and we will not bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may submit to your private insurance company. Such receipts cannot be made available if you are a Medicaid beneficiary (see Medicaid Policy below). We accept Apple Pay, Google Pay, Cash App Pay and Cards (credit and debit cards from Visa, MasterCard, American Express, Discover), Flex Spending Cards, and debit/credit cards (*a convenience fee will be applied*).

Medicaid Policy

If you are a Medicaid beneficiary, you understand that our licensed physical therapists are not enrolled as Medicaid providers. Medicaid has onerous technical and administrative requirements that must be met in order for services to be considered a medically necessary covered benefit(s). We believe those requirements take unnecessary time away from the services we provide. Since the documentation and administrative processing of our services are not designed to meet Medicaid covered benefit requirements, we are not Medicaid enrolled providers and our services will not be covered (paid in full or in part) by Medicaid even if the same services might be considered covered benefits when provided by a Medicaid enrolled provider. We will not submit claims to Medicaid on your behalf or provide you with a statement or billing codes that you can submit to Medicaid yourself. If you want Medicaid to pay for any services that might be considered covered benefits, you should seek those services from a Medicaid enrolled provider. By choosing to receive our services after being fully informed of these facts, you are agreeing with your own free will that you do not want Medicaid involved with the payment for your physical therapy services at Dove Physical Therapy, LLC. You agree to fully pay privately for the services you receive from us even if those services may be covered by the Medicaid Agency and provided by a Medicaid enrolled provider. You also understand that we are not enrolled Medicaid providers and do not meet the technical requirements of Medicaid to cover the services we provide, which

means our services are not subject to the Medicaid maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives, or power of attorney will not, under any circumstances, submit our claims, invoices, receipts, statements, or treatment notes to Medicaid, or to any primary-payer private insurance to receive a reimbursement or a denial notification from a Medicaid supplemental insurance plan.

Self-Payment Policy

If you (the patient) do not have health insurance coverage or would like to opt-out of using your health insurance coverage for payment of your physical therapy services at Dove Physical Therapy, LLC (us, DovePT), the *Self-Payment Option Agreement* may be more suitable for you. Self-payment gives you the freedom of choice to receive health care or physical therapy services with us if DovePT is not in-network with your insurance provider. The length and type of treatment are jointly determined by you and the physical therapist. Your personal information is kept strictly confidential or private unless a specific release of information is signed by you (exceptions as specified by HIPAA). You agree to self-pay the full fee or payment due at the time of service and will not submit/file a claim for payment of services rendered or reimbursement of your payment for services rendered. You have a clear understanding of DovePT's *Financial Policy* and fees as well as your responsibility. You agree that you, your caregivers, family members, authorized representatives, or power of attorney will not, under any circumstances, submit claims, invoices, receipts, statements, or treatment notes on your behalf to any primary-payer and/or private health insurance for reimbursement or to obtain a denial for supplemental health insurance. You understand that you are agreeing to pay privately for the services you receive from DovePT even if those services may be covered by your health insurance plan. You understand that you will be responsible for all charges incurred from treatment(s) a patient of DovePT, regardless of insurance coverage. You understand that signing the Self-Payment Option Agreement is optional, and you can refuse to sign the *Self-Payment Option Agreement* form if you decide to use your health insurance coverage. We accept Apple Pay, Google Pay, Cash App Pay and Cards (credit and debit cards from Visa, MasterCard, American Express, Discover), Flex Spending Cards, Afterpay (*Self-payment Plan only*), debit and credit cards (*a convenience fee will be applied*).

Privacy Rights

You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicaid, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy; and, we will not disclose your medical records to any third party, including your health insurance carrier or Medicaid. If you want your records disclosed to any third party in the future, you will need to obtain and sign our *Disclosure to Release Protected Health Information* form before we will disclose your health information.

I HAVE READ THE *PAYMENT INFORMATION AND CONTRACT* FORM. I UNDERSTAND AND AGREE TO THE ABOVE WRITTEN STATEMENTS AND PAYMENT TERMS.

_____ _____ _____

Patient/Guarantor/Representative Name (Print) **Patient/Guarantor/Representative Signature**

_____

Date

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NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to request that we restrict how PHI about you is used or disclosed. By signing this form, you (the patient) consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. Signing this document also indicates that you have received a copy of our Notice of Privacy Practices on the date indicated. If you have any questions regarding the information set forth in our Notice of Privacy Practices, please contact Aimee Carter, Chief Administrator, at acarterCA@dovept.com, DovePhysicalTherapy@gmail.com, or fax a written notice to (334) 676-1652.

I authorize Dove Physical Therapy, LLC to release my medical information to the following recipient(s) (ex. Family, Relative, Friend, Lawyer, etc.):

Name_____

Relationship_____

Name_____

Relationship_____

Name_____

Relationship_____

_____
Patient/Guarantor/Representative Signature

_____
Relationship If Other Than Patient

_____
Patient Name (Print)

_____
Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Uses and Disclosures of Your Health Information

"I understand that Dove Physical Therapy, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment."

Complaints and Requests

If you would like to submit a request for your records, a comment, or a complaint about our privacy practices or if you believe your privacy rights have been violated, you may contact the Chief Administrator by sending a letter outlining your concerns or requests to:

Chief Administrator
Dove Physical Therapy, LLC
250 Commerce Street
Suite 7
Montgomery, AL 36104

_____
Patient/Guarantor Name (Print)

_____
Patient/Guarantor Signature

_____
Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

HIPAA 143a-Authorization for Release of PHI 10-28-08

(1) **Patient Name (Print)**: _____

(2) **Dove Physical Therapy, LLC will only disclose the protected health information you want disclosed.** Check only one box to tell Dove Physical Therapy, LLC the specific information you want disclosed/released:

□ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)
□ Limited information (complete ALL Sections)
□ ALL records regarding my care at Dove Physical Therapy, LLC to any requesting party (skip 3 and 4)

(3) **Complete only if you selected "Limited information." Please initial all that apply:**

_____ Evaluation/Examination _____ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History _____ Treatments _____Other _____

(4) **Complete only if you selected "Limited information." I only authorize the release of my health information to the following recipient(s) identified below by name:**

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ Physician: _____

(5**) Check only one box indicating how long Dove Physical Therapy can use this authorization:** □ Disclose my information indefinitely (as long as Dove Physical Therapy, LLC has custody of my files) □ Disclose my PHI for the following period beginning ___/___/_____ and ending ___/___/_____

(6) **Please initial all items below indicating that you have read and understand the rights or information below:**

_____I understand that this authorization does not expire unless I have indicated an expiration date above
_____I understand that signing this form is voluntary, and I can refuse to give authorization without fear of retaliation or treatment limitations at Dove Physical Therapy, LLC
_____I understand that if I give authorization, I may revoke it at any time by notifying Dove Physical Therapy, LLC in writing at the address listed above
_____I understand that my health information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient to a third party and may not be protected by applicable "Federal and State" privacy laws and regulations once in the recipient's possession
_____I understand that if Dove Physical Therapy, LLC requests my authorization, it is a requirement to tell me the purpose and to whom my PHI (protected health information) is being released to
_____I understand that I will receive a copy of this authorization after I sign it and before I sign if I request it
_____ I understand that Dove Physical Therapy, LLC will not be compensated for releasing, using, or disclosing my PHI except in instances to obtain payment for services rendered relating to any diagnoses, condition(s), treatment(s), or medical history or unless specific permission is obtained by the patient after full disclosure of purpose and intent

_____ _____
Patient/Parent/Authorized Representative Signature **Date**

_____
Authorized Representative| Indicate the Relationship

You May Refuse to Sign this Authorization

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VERY IMPORTANT (KNOW YOUR INSURANCE BENEFITS)

This form must be completed by the patient receiving physical therapy services before arriving to the first scheduled appointment. You will be provided with a copy upon request.

Determine Your Insurance Benefits Before Your First Physical Therapy Appointment

1. Call the toll-free number for customer service on your insurance card. Select the option that will allow you to speak with a customer service provider, not an automated system.

2. Ask the customer service provider to quote your physical therapy benefits in general. These are frequently termed rehabilitation benefits and can include physical therapy, occupational therapy, speech therapy, and sometimes acupuncture.

3. Make sure the customer service provider understands you are receiving physical therapy services at Dove Physical Therapy, LLC, 250 Commerce Street, 3rd Floor, Suite 7, Montgomery, AL 36104.

Ask the following questions:

A. Is Dove Physical Therapy, LLC *in-network* or *out-of-network* with my insurance? _____
Skip items (B) & (C) if Dove Physical Therapy is in-network.

B. If *out-of-network*, do I have out-of-network benefits/coverage, and how much does my out-of-network benefits reimburse me when I submit the claim? _____

C. What special form does my insurance require me to fill out to submit a claim?
_____

D. How much is my deductible? _____ How much has been met? _____

E. What percentage does my insurance pay for PT? _____ What percentage do I pay? _____

F. What is my co-insurance amount? _____ What is my co-pay amount? _____

G. How many PT visits will my insurance pay for per calendar year? _____
How many remaining PT visits do I have this calendar year? _____

H. What is maximum dollar amount or maximum number of visits limit per year? _____

I. Does my policy require a written prescription from your primary care physician? _____

J. Does my policy require pre-authorization or a referral on file for outpatient physical therapy services?
_____

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INSURANCE VERIFICATION NOTICE

Dear Patient,

Please note that all patients without health insurance will be charged the self-payment fee. We, Dove Physical Therapy, LLC, ***are not*** affiliates or providers for Medicaid agencies. DovePT ***does not*** contract with or accept Medicaid insurances, even if a secondary insurance is coupled with your primary insurance. If you, the patient, wish to receive or continue physical therapy services with this practice, you must self-pay the full amount charged at the time service is rendered. You will be held responsible for the full amount of all charges accumulated at the time of service. Since we do not accept Medicaid insurances, you are paying privately and will be charged the self-payment fee instead. As a self-paying patient, you acknowledge that our office ***will not*** file an insurance claim on your behalf and/or provide you, the patient, with a receipt to submit a claim to Medicaid on your own behalf. If you would like to use your insurance benefits, you may seek treatment at another physical therapy facility that accepts Medicaid insurances. Thank you for understanding and adhering to our policy.

By checking one of the boxes, you are acknowledging that you read and understand our policy outlined above and in all DovePT Patient Registration Forms by confirming your insurance and payment option choice. Please indicate below the payment option (check only one box) that will be used:

☐ My primary insurance is *Blue Cross Blue Shield of Alabama, TRICARE, UnitedHealthcare, Aetna, Viva Health, Medicare, or Veterans Affairs (VA) Community Care Network (CCN).*

☐ My primary insurance is *Medicaid.* I understand that Dove Physical Therapy, LLC does not accept Medicaid. I am voluntarily choosing the Self-Payment Option.

☐ My primary insurance is *Medicaid.* I understand that Dove Physical Therapy, LLC does not accept Medicaid. I am voluntarily declining the Self-Payment Option and physical therapy treatment with Dove Physical Therapy, LLC.

☐ I do not have health insurance coverage. I understand that I will be responsible for the full amount charged at the time service is rendered. I am voluntarily choosing the Self-Payment Option. I understand that I will be charged the self-payment fee.

☐ I do not have health insurance coverage. I understand that I will be responsible for the full amount charged at the time service is rendered. I am voluntarily declining the Self-Payment Option and physical therapy treatment with Dove Physical Therapy, LLC.

Patient Signature *Date*

Dove Physical Therapy, LLC
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INFORMED CONSENT
Informed Consent to Participate in Research Study

Institution/Facility: Dove Physical Therapy, LLC
Type of Research Project: Case Report, Case Series, Case Control Study, Prospective Comparative Study, Randomized Control Trial, etc.
Name of Principal Investigator: Cleve Carter III, PT, DPT, MEd, MTC, CSCS, CLT, C/NDT
Phone Number of Principal Investigator: 334-549-4231

A. PURPOSE AND BACKGROUND
Cleve Carter III, physical therapist at Dove Physical Therapy, LLC, (DovePT) is conducting research on the implementation and utilization of the physical therapy patient management model (examination, evaluation, physical therapy diagnosis, prognosis (plan of care), interventions, and outcomes) related to your medical condition/diagnoses and/or dysfunctions and/or impairments for which you were referred to DovePT. The purpose of your participation in this research is to help the researcher contribute to the body of knowledge in the physical therapy field of study and practice, to identify the best practices in physical therapy, and to advance the field of physical therapy by sharing research findings through peer-reviewed journals and/or scholarly journals, book chapters, etc. You were selected as a possible participant in this study because you meet the criteria for this research study.

B. PROCEDURES
If you agree to participate in this research study, the following will occur:
1. The physical therapist (PT) will implement and utilize the physical therapy patient management model (examination, evaluation, physical therapy diagnosis, prognosis (plan of care), interventions, and outcomes) will occur.
2. The PT will obtain a subjective history, conduct a system review, administer outcome measurement tools/questionnaires, and perform tests and measures to gather data.
NOTE: *Data collection methods may consist of audio, video, written, or pictures taken after each treatment session or on every reassessment session.*
3. The PT will make clinical judgments based on data gathered during the examination.
4. The PT will formulate a clinical impression and determine the prognosis (including the plan of care) and the most appropriate intervention strategies.
5. The PT will determine the level of optimal improvement that may be attained through intervention and the amount of time to reach that level.
6. The PT will use various physical therapy procedures and techniques, as discussed on the initial PT examination/evaluation, to produce changes in the condition that are consistent with the diagnosis and prognosis.
7. The PT will inform you, the patient/client, about the results which will include the impact of the physical therapy interventions. In addition, the PT will use the information and/or data (keeping all personal information anonymous) to write research article(s), book chapter(s), etc. for publication.

C. RISKS
Risks are written and detailed in the Waiver and Release of Liability on page 5 and Informed Consent on page 6. By signing the Waiver and Release of Liability on page 5 and Informed Consent on page 6, you agree that you acknowledge the risk of this research study.

D. CONFIDENTIALITY
The records from this study will be kept as confidential as possible. No individual identities will be used in any reports or publications resulting from the study. All data collection will be given codes and stored separately from any names or other direct identification of participants. Research information will be kept in locked files at all times. Only research personnel will have access to the files and data collection. Only those with an essential need to see names or other identifying information will have access to your particular file. In this case, the journal in which I submit an article for publication may request supporting documentation to support the research conducted. After the study is completed, your physical therapy chart will be kept and locked in storage for up to five (5) years. After five (5) years, your physical therapy chart will be discarded by a shred machine.

E. BENEFITS OF PARTICIPATION
There will be no direct benefit to you from participating in this research study. The anticipated benefit of your participation in this study is potentially positive outcomes with physical therapy services.

F. VOLUNTARY PARTICIPATION
Your decision whether or not to participate in this study is voluntary and will not affect your relationship with DovePT. If you choose to participate in this study, you can withdraw your consent and discontinue participation at any time without prejudice.

G. QUESTIONS
If you have any questions about the study, please contact the principal investigator/researcher at 334-549-4231 at any time. This research study is not associated with a "University" or "College;" thus, no Institutional Review Board is involved in this research process.

CONSENT: *YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN A RESEARCH STUDY. YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE IN THE STUDY AFTER READING ALL OF THE INFORMATION ABOVE AND YOU UNDERSTAND THE INFORMATION IN THIS FORM, HAVE HAD ANY QUESTIONS ANSWERED AND HAVE RECEIVED A COPY OF THIS FORM FOR YOU TO KEEP.*

_____ _____
Research/Patient Participant Name (Print) ***Date***

_____ _____
Research/Patient Participant Signature ***Date***