CITY PHYSICAL THERAPY, PC

PATIENT CONSENT FORM
患者知情同意書

PATIENT NAME: _____
患者姓名

1. CONSENT FOR CARE AND TREATMENT

Layman's Terms: You allow us to treat you.
I hereby give my consent to City Physical Therapy, P.C. and its agents to provide medical/rehabilitative evaluation and treatment to me considered necessary and proper in diagnosing and/or treating my condition.

同意接受治療

條款要点: 您允許我們對您進行治療。

我同意 City Physical Therapy, P.C. 及其相關代理針對我提供必要的醫學/康復評估，並進行合理的診斷和(或)治療。

2. BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

Layman's Terms: You allow us to release your information to your insurance company and you authorize your insurance company to pay us for the services we render.
I hereby assign all medical benefits (Major Medical/Commercial Insurance, Medicare, Worker's Compensation, No-Fault, etc) related to the care provided by City Physical Therapy, P.C. and/or its agents, to City Physical Therapy, PC. A photocopy of this assignment is to be as valid as the original. I hereby authorize said assignee to release all information necessary including Medical Records, to secure payment.

醫療保險授權及醫療信息公開權

條款要点: 您同意我們將您的醫療信息提供給您的保險公司，並且授權您的保險公司為我們提供的服務支付費用。

我同意所有與本人相關的醫療福利機構與公司，包括商業醫療保險、政府醫療保險(即紅藍卡)、工伤、机动车無過失保險等，均可直接支付受讓人City Physical Therapy P.C. 及其代理所提供服務的相關費用。該醫療授權文件的影印本與原件具有同等的法律效用。我授權該受讓人向相關的醫療福利機構提供必要的醫療紀錄以確保得到費用的支付。

3. PRIVACY PRACTICES

Layman's Terms: We will only use your personal information for healthcare operations and we will not sell your information to a 3rd party.
I understand that City Physical Therapy, P.C. will use protected health information (PHI) for the purpose of treatment, payment, and heath care operations. I have been presented with the City Physical Therapy, P.C. Notice of Privacy Practices.

个人信息保密協議

條款要点: 您的個人隱私信息將僅限於醫療保健業務，我們不會將您的個人隱私信息轉讓給第三方。

我理解 City Physical Therapy P.C. 因治療、費用支付、及相關醫療業務，而需使用我的受保護健康信息(PHI)。我聲明 City Physical Therapy, P.C. 向我提供了相關的隱私保密協議。

4. DIRECT ACCESS POLICY

In NY State, patients can be seen in PT for 10 visits or 30 days (per condition/episode) without a physician's prescription. After 10 visits or 30 days, **ALL** patients require a prescription. Medicare, Worker's Compensation, and No-Fault patients are not eligible for direct access and always require a prescription.

無處方診療政策

根據紐約州法律規定，患者在沒有醫生處方的情況下，可就不同症狀或在不同發病週期內直接接受不超过10次或30天的物理診療。在10次或30天物理診療以後，所有患者均需提供醫生處方。此政策不适用于持紅藍卡(政府醫療保險)，工伤和机动车無過失保險的患者。此類患者按紐約州法律規定必须提供醫生處方。

5. MEDICARE PHYSICAL THERAPY PLAN OF CARE (POC) POLICY (Medicare Patients Only)

Medicare requires the referring physician to sign off on the PT POC every 30 days. We will make 3 attempts to contact your doctor to secure their sign off. If your doctor does not sign off we will ask you to contact/visit your doctor. We will stop scheduling appointments if your POC is unsigned for more than 45days.

紅藍卡醫生簽署治療計劃政策 (僅限紅藍卡患者)

政府醫療保險(即紅藍卡)要求轉診醫生每30天簽署一次理療治療計畫文件。為確保醫生簽署您的文件，我們會联系您的医生，若您的醫生在3次聯繫後还未能簽署該文件，我們會要求您聯繫/拜訪您的醫生。如果該文件超過45天仍未被您的醫生簽署，我們必须停止治疗并取消您的預約。

6. NO SHOW/ LATE CANCEL POLICY

If you need to cancel your appointment, please do so 24 hrs in advance. If you cancel your appointment with less than 24-hour notice or No-Show, there will be $50 charge.

缺席/取消預約政策

如果您需要取消預約，請提前24小時與我們取得聯繫。如果您未提前24小時通知或者沒有在預約時間到场，我們將收取$50違約金。

I have read and agree to the terms/policies set forth above in the "Consent for Care and Treatment", "Benefit Assignment and Release of Information", "Privacy Practices", "Direct Access Policy", "Medicare PT POC Policy", and "No Show/Late Cancel Policy".

我已閱讀並接受上述 "同意接受治療"、"醫療保險授權及醫療信息公開權"、"個人信息保密協議"、"無處方診療政策"、"紅藍卡醫生簽署治療計畫政策" 及 "缺席/取消預約政策" 篇章所列的相關條款/政策細則。

Signature of Patient, Authorized Representative or Responsible Party 患者簽名/患者授權代理簽名/責任方簽名	Date 簽署日期
Print Name of Patient, Authorized Representative or Responsible Party 請用工整字跡填寫患者姓名/患者授權代理姓名/責任方姓名	Relationship to Patient 與患者的關係

PATIENT CONSENT FORM
(Continued)
患者知情同意書
（接上）

7. PAYMENT POLICY

付款政策

- **Copay**: Due at the time of each visit in-office, via Cash or Check or Chase Quick Pay/Zelle ONLY.
  保險共擔費: 每次就診均須支付，可用現金、支票或者大通Quick Pay/Zelle快速付(Chase Quick Pay/Zelle)支付。
- **Deductible/Coinsurance**: You will be contacted when claims are returned from your insurance with EOBs (Explanation of Benefits) indicating your responsibility, which will then be charged to your credit card on file.
  保險起始費/共險費: 您的保險公司處理完您的費用申請后會向我們提供費用判定報告(EOBs, Explanation of Benefits)指出您是否有所需承擔的餘額。屆時們會聯繫您並通過您預留的銀行卡扣除相關費用。
- **Bounced check fee**: if you pay by check and your check does not clear, you will be charged an additional "bounced check fee" of $50 in addition to any bank charges that we incur.
  空頭支票/退票費用: 如果您用於支付的支票無法兌现，我們會額外收取$50退票費以支付銀行向我們收取的費用。

8. PATIENT FINANCIAL RESPONSIBILITY

患者的經濟責任政策

- I understand that I am financially responsible for my health insurance copay, deductible, coinsurance, and non-covered or not-payable services.
  我理解我對醫療保險附屬的共擔費、起始費、共險費，以及非受保項目費用或受保項目餘額承經濟責任。
- If my plan requires a referral, I must obtain it prior to my visit.
  如果我的醫療保險要求醫生轉診，我需在就診前得到轉診許可。
- I will immediately notify City Physical Therapy, PC to any changes in my insurance coverage.
  我會及時告知 City Physical Therapy, P.C. 任何有關我的保險公司或保險计划的變化。
- In the event that my health plan determines a service to be "not payable", or reverses a previous processed claim and takes back the prior payment, I will be responsible for the complete charge and agree to pay the costs of all services provided.
  若我的保險公司費用判定報告判定部分或全部服務不屬保險覆蓋範圍內，並拒絕支付或撤回已支付費用，我有責任承擔所有剩餘費用。
- **Insurance direct payment**: If any payment is made directly to me for services provided by City Physical Therapy, P.C. and/or its agents, I recognize an obligation to promptly remit same payment to City Physical Therapy, P.C.
  保險直接支付款項: 如果我的保險公司直接向我支付理療相关的服务款项我明白我有義務將該款項的全額及時交付給 City Physical Therapy, P.C.

- **Collections**: I understand and agree that if I fail to make the payments for which I am responsible fully and in a timely manner, I will be responsible for all costs collecting monies owed, including court costs, collection agency fees, and attorney fees.
  欠款逾期/拒付費用: 我理解並且同意如果我未能按時履行经济责任或拒绝履行经济责任，我將為欠款及因逾期產生的任何費用负责，包括訴訟費、代理費、律師費等。

- Prior to your first visit we verified your insurance benefits for Physical Therapy, which are listed below:
  在您就診前，我們對您保險的理療福利進行了核實。你的理療福利如下:

Primary insurance: _____
主要保險

PT visits per year: _____
年限理療次數

Secondary insurance: _____
其他保險

Visits used: _____
已使用理療次數

- **ESTIMATED PATIENT RESPONSIBILITY (provided by your insurance co. prior to treatment, and not a guarantee of payment until your insurance co. processes claims)**:
  預估就診費用 (由保險公司在就診前提供，並在收到費用判定報告前無法保證最終金額):

Deductible: _____
保險起始費

Eval: _____
首診/重診費

(estimated for Ded/Coins)
(仅适用于保險起始/共險費)

Copay/Coinsurance: _____
共擔費/共險費

Follow-up: _____
后续就診費

(estimated for Ded/Coins)
(仅适用于保險起始/共險費)

*Aetna may apply a one-time deductible ($35 - $49) to the evaluation and re-eval visits in addition to your normal co-pay responsibility, depending on your plan benefits.
* 安泰保險公司(Aetna): 根據您具體的保險福利，在正常共擔費外，每次診斷/重診時可能会額外收取$35-$49的一次性費用。

I have read and agree to the terms/policies set forth above in the "Payment Policy", and "Patient Financial Responsibility".
我已閱讀並接受上述規定的 "付款政策"、"患者的經濟責任政策" 相關的條款/政策細則。

_____ _____
Signature of Patient, Authorized Representative or Responsible Party
患者簽名/患者授權代理簽名/責任方簽名

Date
簽署日期

_____ _____
Print Name of Patient, Authorized Representative or Responsible Party
請用工整字跡填寫患者姓名/患者授權代理姓名/責任方姓名

Relationship to Patient
與患者的關係