PATIENT RIGHTS - The following list of patient rights is not intended to be all inclusive. Every patient has the right to:

- Considerate and respectful care, including your psychosocial needs, personal values, belief systems, and dignity.
- Communicate with those responsible for your care, to receive information concerning the nature and extent of your medical condition, the planned course of treatment and prognosis.
- Inquire as to the name and role of anyone treating you if you do not know.
- Refuse treatment and to be informed of the medical consequences of your action.
- Privacy and confidentiality concerning your treatment program and records. Case discussion, consultation, examination, treatment will be conducted discreetly and your records kept confidential.
- Examine and receive an explanation of your bill, regardless of your source of payment.
- Access the information contained in your medical record within the limits and specific provisions of Priority Physical Therapy, Inc. policy.

PATIENT RESPONSIBILITIES - Your care not only involves the rights listed above, but your responsibility to:

- Schedule all your appointments for the treatment period as recommended by your physical or occupational therapist.
- Arrive promptly for all scheduled appointments. If you are unable to keep an appointment, 24 hour notification of the cancellation is expected. Refer to "No Show Policy" below.
- Priority Physical Therapy, Inc. has the right to considerate and respectful responses and communication from you.
- Share with your physical or occupational therapist information about past illnesses, hospitalizations, medications, and other matters relating to your health and recovery.
- Cooperate with all Priority Physical Therapy, Inc. personnel caring for you and to ask questions if you do not understand directions given to you.
- Make known, as soon as possible, any grievances to the proper personnel so that action can be taken to correct any problem concerning personnel, policy or procedure.

PRIVACY, CONFIDENTIALITY AND RELEASE OF PATIENT RECORDS

Subject to applicable law and regulation, patient records will be released or provided only upon appropriate authorization, consent or request, signed by the patient or his/her authorized representative. Upon at least 24 hours notice, and payment of copy and other charges permitted by law, Priority Physical Therapy, Inc. will also release to the patient and their designated recipients' copies of the patient's medical records. For additional authorization to release patient medical records, please consult your therapist or other representative of Priority Physical Therapy, Inc.

NO SHOW / CANCELLATION POLICY

If you fail to show for an appointment or give less than 24 hours notice of cancellation of an appointment, your visit may be considered a "No Show" appointment.

- 1st occurrence: Documented in your physical or occupational therapy record.
- 2nd occurrence: Also documented, and will result in a $25 charge to your account billed directly to you (not a covered insurance benefit).
- 3rd occurrence: Documented, $25 charge, and will also result in removal of all future appointments from the schedule; your physical or occupational therapist's approval will be required for additional appointments.

A pattern of repeated cancellations may also result in removal of appointments from the schedule per above.

By signing below, I acknowledge that I have reviewed the above material and I understand and agree to comply with the policies and procedures set forth.

X ______________________________ X ______________

Patient Signature (or authorized Patient Representative if patient is unable to sign) Date

INFORMED CONSENT FOR TREATMENT

During your evaluation and treatment with Priority Physical Therapy, Inc., you will be asked to cooperate to the best of your ability. We, in turn, will do our best to avoid any hazardous or uncomfortable situations for you. Some of the testing and treatment may carry some risks. There may be some discomfort or pain; or possible strain or re-injury from overexertion. At all times, you have the right to stop the testing or treatment if the pain becomes more than you feel that you can tolerate or are used to. If you have any heart, lung or general medical conditions, you must tell the provider. Failure to inform the provider may cause serious complications or possible injury. If your injury is work related, it must have been reported to the employer to be covered by worker's compensation insurance. If there is a dispute regarding the cause of the nature of the injury, or if the claim is not paid as worker's compensation claim, then you, the patient, will be responsible for payment. I hereby authorize the staff of Priority Physical Therapy, Inc. to examine and treat me with physical or occupational therapy procedures and modalities necessary for the injury/diagnosis for which I have presented here. I also authorize Priority Physical Therapy, Inc., to send me appointment reminders, messages and the like pertaining to my care via electronic mail, voice mail message or physical address at the numbers and addresses I provide on this form and otherwise:

Telephone number(s)______________________________ ______________________________ ______________________________

Email address(es) ________________________________

Can we identify ourselves as Priority Physical Therapy, Inc. and leave a message? (check all those that apply):

_____at home _____at work ____cell phone _____answering machine _____all of above

Can we talk or leave a message with (check all those that apply): _____only myself ____whoever answers _____other, specify who__________________

By signing below, I acknowledge that I have reviewed the above material and understand and agree to comply with the policies and procedures set forth.

1. Have you had any physical or occupational therapy in the past year? _____No _____Yes; If Yes, When?________________

   Where?__________________________ For What Condition(s)/Diagnosis?____

2. Have you had any home care services in the past year? _____No _____Yes; If yes, Agency ________________When?__________________

3. Do you have a Power of Attorney for Healthcare? _____No _____Yes 4. Do you have an Advanced Directive? _____No _____Yes

5. How did you hear of Priority Physical Therapy, Inc.? ____ _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH CARE PROVIDER

Insurance company name(s): ______________________________________ _________________________

I hereby instruct the above named insurance company(ies), any other insurance company(ies) having coverage, and my attorney, upon judgment, verdict or settlement, to pay directly by check made out to and mailed to: Priority Physical Therapy, Inc., 413 N. 17th Ave. Suite 100, Wausau, WI 54401, for any and all medical and professional fees and expenses awarded, allowable and otherwise payable to me on settlement, verdict or judgment, or under any applicable insurance policy as payment toward the total charges for such services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THESE POLICIES. This payment will not *exceed* my indebtedness to Priority Physical Therapy, Inc., and I have agreed to pay promptly any balance of said charges for professional services for non-covered services and/or fees, over and above the insurance payment, or as required by my insurance policy or law. I also agree to pay all co-payments, deductibles, and any portion of [allowed] charges that my insurance does not pay. I authorize the release of any medical and other information pertinent to my case; (a) to any insurance company, adjuster, or attorney for the purpose of processing my insurance claims and securing payment under any policy of insurance directly to Priority Physical Therapy Inc., and (b) to any medical provider associated with my case to effectively treat me. A photocopy of this Assignment and Instruction shall be considered effective and valid as the original. In addition, I grant Priority Physical Therapy, Inc., a security interest and lien in, against and on the proceeds of any judgment, verdict or settlement which may be payable or paid to me or my attorney for injuries received in any accident or incident for which I received treatment services by Priority Physical Therapy, Inc., in the amount of any unpaid balance for such treatment services. I also agree to pay a late fee on any balance past due to Priority Physical Therapy, Inc., for more than 90 days, at the rate of 1.5% per month, not exceeding 18% per annum. If my account is placed with an agency or attorney for collection, I agree to pay all collection expenses, including reasonable attorney fees.

X____ X____________________________

Patient Signature (or authorized Patient Representative if patient is unable to sign) Date

____ ____________________________

Print Name Relationship to Patient

____ ____________________________

Signature of Witness Date