Medcessity
Physical, Occupational, & Hand Therapy
*Caring is a Medical Necessity and Our Business!*

# Clinic Information

**Mission Statement**

**"Care is a Medical Necessity and Our Business!"**

We ***care*** to make a positive impact on the lives of our Clients, our Colleagues, and our Community.

Our priority is to provide **Personalized, Considerate, and Compassionate Care.**

Welcome to **Medcessity: Physical, Occupational, & Hand Therapy**. We are pleased you have chosen our office to meet your therapy needs. The following will help us provide the highest quality of care:

1. Please Provide a **Picture ID** and your current **Health Insurance Card** (if applicable).
2. Notify us immediately of any health insurance changes during the course of treatment to avoid any unforeseen financial responsibilities.
3. If you have had any therapy (PT, OT, Chiro, Home Health) earlier this year, please let us know immediately as it may affect your insurance benefits and cause unexpected financial responsibilities.
4. If you have been waiting longer than ten (10) minutes past your appointment time, please notify the receptionist at once.
5. If you are more than 15 minutes late to your appointment time, you may have to reschedule.
6. Should you need to cancel or reschedule an appointment for any reason, please call **(562)428-3556** or email at: **Frontdesk@Medcessity.com,** with at least 24 hours notice. The reception desk is open from 8:00 a.m. to 6:30 p.m., Monday through Friday.
7. **NO SHOWS or LATE CANCELLATIONS made with less than 24 hours notice, may be subject to a $35 late cancellation fee.**
8. Visitors / family members are welcome, but they may have to stay in the waiting room if space becomes an issue in the treatment area. Children under the age of 14 may not be allowed in the treatment area alone and must be accompanied by an adult.
9. You may be discharged from therapy if:
    a. You meet your therapy goals.
    b. You have not received therapy within a 4-week period.
    c. You cancel 3 or more appointments in any 2-week period.
    d. You do not show for 3 consecutive appointments without calling to cancel.
    e. You are hospitalized.
10. To restart therapy, you may need to obtain a new prescription from your physician.

***Initial:*** _____

**We wish to make your therapy experience unique and personal. If you have any questions or concerns, please let us know. Once again, thank you for choosing Medcessity: PT, OT, and Hand Therapy for all yours and your family's physical rehabilitation needs.**

**The Medcessity Team**

4010 Orange Ave; Long Beach, CA 90807
Tel.: 562-428-3556 ♦ Fax: 562-428-3621 ♦ Email: Contact@Medcessity.com

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# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

-I consent that **Medcessity** may use, disclose and/or request protected health information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPHO). Please refer to **Medcessity**'s Notice of Privacy Practices for a more complete description of such uses and disclosures.
-I have the right to review the Notice of Privacy Practices prior to signing this consent. **Medcessity** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Medcessity**'s Privacy Officer at the address or listed below.
-I consent that **Medcessity** may *call, video call, leave messages, text, mail to, and/or email* using my listed contact information and/or other designated location(s) in reference to any items that assist the practice in carrying out TPHO, such as appointment reminders, insurance items, bills/statements and/or any thing pertaining to my clinical care and account, as long as written items are marked *Personal and Confidential.*
-I have the right to request that **Medcessity** restrict how it uses or discloses my PHI to carry out TPHO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
-I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.
If I do not sign this consent, **Medcessity** may decline to provide me with treatment.

Furthermore, I hereby consent to the prescribed therapeutic procedures to be performed by **Medcessity, Inc.** and its associates would it be in-person or via telehealth services. I understand that no assurance can be given as to the success of the prescribed treatment. I acknowledge that **no** guarantee or warranty of success has been given to me.

I also consent to **Medcessity** may take photographs, use video streaming if necessary for consultations and documentation purposes.

**Financial Agreement** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the services not otherwise paid by my health insurance or other payor. All charges are due and payable upon receipt of the bill. If payment is not made within 90 days after receipt of the bill, a delinquent charge and/or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file.
**Assignment For Direct Payment** I authorize and direct that payment of any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to **Medcessity, Inc.** I understand that I am financially responsible to Medcessity, Inc. for charges not covered or paid pursuant to this authorization.
A fee may be applied to payments made by credit or debit cards.
If my account should become delinquent and collection services required, a charge of $35.00 will be added to the outstanding balance.

**Late Cancellation Policy**
Last minute cancellations and "no-shows" are not only inconsiderate to your therapist, but also unfair to other patients that wanted your appointment time. We will do our best to work with your scheduling needs when setting up your appointments, as well as encourage you to set up appointments in advance so that you get your preferred time. However, we ask in return that you provide us a 24-hour notice of cancellation, so that other patients may be scheduled in your place. We understand that emergencies are unplanned, but we still ask that you call us at first notice that you are unable to attend your appointment. Office hours are Monday-Friday 8:00am to 6:30 pm with lunch from 12:00pm to 1:00pm. We also have an answering machine for you to leave your messages at all hours.

Failure to provide us with such notice will result in a **$35 cancellation charge**. Most insurance companies will not cover cancellation fees, so please note that you may be fully responsible for these charges.

**"I UNDERSTAND THE ABOVE POLICY AND AM AWARE THAT IF I FAIL TO PROVIDE 24-HOUR NOTICE OF CANCELLATION, I MAY BE CHARGED A LATE CANCELLATION FEE."**

SIGNATURE ON FILE
Patient or *Representative's* Signature

Today's Date

*Representative Name, if applicable*

*Relationship to the Patient*

SIGNATURE ON FILE
**Medcessity**'s Representative, as a witness

Today's Date