OPTCI OSTEOPRACTIC PHYSICAL THERAPY OF CENTRAL INDIANA
ORTHOPEDIC AND PELVIC HEALTH SPECIALIST

Communication Approval Form

We would like to be able to better serve you and give you the best patient care possible. By signing below, it gives Osteopractic Physical Therapy of Central Indiana, LLC permission to contact you through cell phone, text, video, or email to answer questions and to give you efficient, personalized service. By choosing to use the convenience of e-mail and text to communicate, you understand and agree to the following:

The use of e-mail and text may pose risks to the confidentiality of your health information and the content you share. The cell phone and internet are open networks and provides no inherent protection for confidential information, and you accept these risks.

_____ (**initial**) I give Osteopractic Physical Therapy of Central Indiana, LLC permission to contact me via cell phone, text, video, and email and I understand the above statements

Email Address_____

Preferred choice of communication: (circle)

Phone call Email Text

Good Faith Estimate

The No Surprise Act was passed to help protect patients from receiving unexpected medical bills and to receive a good faith estimate to know the expected cost of care. My treatment plan has been reviewed with me fully and I have been given the opportunity to ask questions. I confirm that I have received the No Surprise Billing Protection Form and fully understand my Good Faith Estimate for the cost of my treatment at Osteopractic Physical Therapy of Central Indiana.

Name of Patient:
(Print)_____

Facility: Osteopractic Physical Therapy of Central Indiana, LLC

Estimated Total Cost Of Treatment:
_____

Signature of Patient: _____
Date:_____

OPTCI
OSTEOPRACTIC PHYSICAL THERAPY OF CENTRAL INDIANA
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Your health is our priority.
Empower. Challenge. Purpose.