OFFICE POLICY

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I ,the undersigned, do hereby agree and give my consent for **Sport & Spine Physical Therapy, Inc.** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Sport & Spine Physical Therapy, Inc.** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $50 for a physical therapy visit. This will be billed directly from our billing company, BMS. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

CO-PAYMENTS: Per our contracting guidelines, co-payments are due at the time of service.

NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds may be subject to a $25 processing fee.

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. You are responsible for any balance on your account after the insurance company pays their portion. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred.

- I choose to self-pay at a discounted cash rate. I further understand that no insurance company will be billed and that I cannot change from this option during my course of treatment. Please initial:_____
- I have verified my outpatient physical therapy benefits with my insurance company and understand that it is my responsibility to know the extent of my benefits. Please initial:_____
- Do I need a referral from my primary care physician? Yes ☐ No ☐
  Co-pay amount per visit $_____ Co-insurance amount I am responsible for_____%
  Number of physical therapy visits allowed_____ Maximum amount allowed per calendar year_____

The above financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Sport & Spine Physical Therapy, Inc.** to treat_____(minor's name) while I am not present.

Patient/Guardian/Responsible Party Signature **Date**

Please print name

Clinic Representative **Date**