Performance Physical Therapy & Sports Conditioning

PATIENT: _____

Patient/legal custodial guardian/parent responsibilities:

◘ Confirming & understanding the benefits the insurance plan provides for outpatient physical therapy treatment. If a referral form is required, I understand I am responsible for obtaining one. If I do not provide a referral form and choose to proceed with physical therapy, I will be responsible for payment at time of service. It is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I am aware that the Insurance company reserves the right to make final decisions until processing the bill.

◘ I understand that all copays/coinsurance amounts are due at time of service or weekly payable by cash, check or Venmo only. **Further appointments will be cancelled if copayments are not paid within 1 week of your appointment. .** I understand that I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges for home exercise equipment, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. collection agency, court or attorney costs).

Also, please be advised our office may contact you via telephone/email regarding appointments and/or account status.

If you are seeking legal counsel for an injury, please be aware that we do not accept letters of protection and you will be financially responsible for treatment at time of service.

◘ **No Show:** If you are unable to keep an appointment and fail to notify our office, a **NO SHOW FEE of $50** will be charged. This fee will be your responsibility and will not be submitted to insurance. The office will attempt to contact the patient and confirm or schedule another appointment. If the office does not receive a return call, all further appointments will be cancelled (if applicable). The referring physician will be notified that the patient is non-compliant with their physical therapy program.

◘ **Cancellation**: We encourage our patients to notify our office within a timely manner, at least 4 hours in advance (preferably 24 hours in advance). Failure to notify our office will result in a **CANCELLATION FEE of $50.** This fee will be your responsibility and will not be submitted to insurance. Prior to continuing with treatment, this fee must be paid along with any other outstanding fees.

◘ **Inclement Weather**: For your safety and ours, in case of inclement weather, we ask that you follow the above cancellation policy. At times, we may not be able to make it in due to inclement weather and will attempt to notify you. If you intend on making your appointment during inclement weather, please call to make sure we are open.

◘ **Returned Checks:** A fee of $30 will be applied to patient's account for any returned checks.

◘ **Patient Records:** A fee of $1.00 per page will be charged as allowed by State requirements for copying medical records. A record search fee of $15 will also be applied and will be additional to the copying fee.

I hereby give my authorization to Performance Physical Therapy & Sports Conditioning, through its appropriate personnel to use or disclose the above patient's protected health information to any person(s) and/or organization that is responsible for payment on patient's account until advised otherwise. Notice of privacy practices is visible and if I choose to have a copy of this notice for my records, I have the right to request one.

I authorize payment of medical benefits to Performance Physical Therapy & Sports Conditioning from my insurance carrier(s). I authorize Physical Therapy & Sports Conditioning to appeal any insurance denials on my behalf as my designated representative.

I consent to treatment necessary for the care of the above named patient.

DATE: _____ **SIGNATURE:**_____

If patient is a minor and/or unable to sign, legal custodial guardian or parent must sign