S.P.O.R.T. PHYSICAL THERAPY

Patient Name: _____ **DOB:** _____

CONSENT FOR TREATMENT

As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. We encourage you to discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them. It is understood that SPORT Physical Therapy Clinic shall not be liable for loss or damage to any personal items brought to SPORT Physical Therapy Clinic during the course of treatment

I, the undersigned, authorize the staff at SPORT Physical Therapy Clinic to undertake such treatment and procedures as deemed approproate to improve my condition.

CANCELLATION / NO-SHOW POLICY

Our commitment to your wellbeing is something everyone at SPORT Physical Therapy Clinic takes very seriously. Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need. In the event you need to cancel your appointment, **WE REQUIRE A MINIMUM 24-HOUR CANCELLATION NOTICE.**

Emergency siutations and personal illnesses do occur that may make it impossible to keep a scheduled appointment. In those instances, we will not charge you the missed appointment fee of **$35**. Please be advised that a second cancellation of an appointment outside of the required 24-hour notice period may result in a fee of **$35**. The cancellation fee is a non-billable fee to your insurance company and is your responsibility. Please keep in mind that should your therapist encounter an emergency situation or become ill and your appointment is rescheduled as a result, you will not be assessed a fee.

Additionally, when patients do cancel appointments, we will make every effort to minimize the impact to the therapist's schedule. We may, on occasion, contact patients to see if moving them to another time is convenient for both parties. If you are able to accommondate, we sincerely appreciate your flexibility. By the same token, if you find that you have a schedule change that conflicts with your previously scheduled appointment, we encourage you to call as quickly as possible to reschedule. If the required schedule change falls outside of the 24-hour notice period but one that we can easily accommodate, you will not be assessed the cancellation fee of $35.

If you **miss an appointment without notice**, unless it falls under one of the exceptions mentioned above, you may be charged a **$50** no-show fee. Please be advised that this no-show fee is a non-billable fee to your insurance company and is your responsibility.

Repeated cancellations and/or not showing up to appointments do not align with SPORT Physical Therapy Clinic's mission. Please be advised that if you cancel and/or no-show for three appointments, we may elect to discharge you from care and send your referring provider a note regarding your non-adherence to your therapy plan of care.

Updated 7.1.2019

FINANCIAL POLICY / FINANCIAL AGREEMENT

You are encouraged to contact your insurance provider for verification and clarification of allowed benefits. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS AND TO KNOW WHICH PROVIDERS AND NETWORKS ARE COVERED BY YOUR INSURANCE COMPANY!** Some insurance plans have limits, either monetary or numerical, as to how many outpatient physical therapy visits they will cover. It is important to understand your individual plan. **As a courtesy to you, we will try to provide you with the most up-to-date information about your benefits, but ultimately, you are expected to know your co-pay and deductible amounts and benefits.**

Your insurance policy is a contract between you and your insurance carrier – we are not a party to that contract. As a courtesy to you, SPORT Physical Therapy Clinic will submit claims to your insurance carrier in a timely manner. In order to facilitate claims processing, you MUST provide SPORT Physical Therapy Clinic all insurance policy information and any changes to your insurance. In most instances, we will accept payment directly from your insurance company in accordance with your policy's terms and apply the payment to your account. Contractual discounts will be applied at that time.

If SPORT Physical Therapy Clinic will be billing a worker's compensation carrier, it is imperitive that we receive your claim information as quickly as possible. We also require your personal insurance information in the event that your worker's compensation claim is denied.

If you do not have insurance coverage, you will be expected to pay your bill, in full, at the time of service or make appropriate payment arrangements. For your convenience, we accept cash, checks, and major credit cards and debit cards. SPORT Physical Therapy Clinic will not bill any insurance plan at a later date if the patient/legal guardian elects to be Self Pay at the time of service.

TERMS OF AGREEMENT

I, the undersigned, hereby agree with the following:

- All co-payments must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on the part of SPORT Physical Therapy Clinic to collect co-payments from patients may be considered fraudulent. I agree to pay my co-payment at each visit.
- I am aware that some, and perhaps all, of the services/supplies I have received may be non-covered, denied by my insurance company, or not considered reasonable or necessary by my insurance company. I understand that I am financially responsible for all charges not paid by my insurance company.
- I will present a copy of a current, valid insurance card to provide proof of my existing insurance coverage. I will notify SPORT Physical Therapy Clinic of any change in my information, including but not limited to, address, phone number, and insurance coverage.
- My insurance company may need for me to supply certain information directly. It is my responsibility to comply with all requests. I am aware that insurance coverage does not guarantee payment of services.
- I understand that I am financially responsible for all charges not paid by my insurance company. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance claims.
- I understand, that despite any possible pending settlement, such payment for services is not contingent on any settlement, judgment, or verdict by which I may eventually recover.
- I understand that I may be assessed a charge of $35 for untimely appointment cancellations and $50 for no-show appointments. These charges are my responsibility and not covered by my insurance.
- I understand that I will be charged a $25 fee for issuance of a non-sufficient funds check. This charge is my responsibilty and not covered by my insurance.

I have read and understand the above Consent for Treatment, Cancellation and No-Show Policy, and Financial Policy/Agreement and agree to all terms above.

_____ _____

Patient/Guardian/Representative Signature **Date**