PT Now
Physical Therapy for Health, Sport & Wellness

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Consent for Care and Treatment

I, the undersigned, do hereby agree and give consent for Physical Therapy Now to provide physical therapy treatment to_____ as considered necessary and proper by his/her referring physician in diagnosing or treating his/her physical and mental condition.

Benefit Assignment/Release of Information

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to Physical Therapy Now. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Protected Health Information

I have received the notice of Privacy Practices for Protected Health Information from Physical Therapy Now. I understand and agree that my protected health information will be handled in accordance with the US Dept of Health and Human Resources, Health Insurance Portability and Accountability of 1996.

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that co-pays and/or patient estimated share be made today. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of the money refunded to your insurance company. In the event your insurance company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining, if we are a non-participating provider.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the payment to Physical Therapy Now. In the event you have Empire BCBS as your insurance carrier your payment is due at the time of each visit.

The above does not apply for those patients that are Worker's Compensation. However, be advised if you claim W/C and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for the costs of collecting monies owed, including court costs, collection agency fees of 33.3% and attorney fees.

I understand and agree any appointment cancelled without 24 hours notice will be subject to a $25.00 fee.

Our office has a policy of "No Cell Phone Use".

Co-pay or estimated share amount _____

Note: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

I have read the above information and understand my responsibility for the payment of my account.

Patient/Guardian_____ Date _____

Witness Signature _____ Date _____