Consent for Physical Therapy

I consent to physical therapy services at **Elite Physical Therapy**. I know that if I have any questions or concerns about my care, I should be sure to ask the physical therapist about them. I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist or supportive personnel.

Financial Policy

Payment: All payments including copay, coinsurance and deductible are due on the date of service. We accept cash, checks, Visa, MasterCard, American Express and Discover credit cards. As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.

Coinsurance/Deductible: If you have an insurance plan with coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been lead to expect your insurance company will pay. Please note that any payment made on the date of service is considered a D**EPOSIT** toward your **ESTIMATED** patient balance. Because this is an estimate, there is always the possibility that you will be responsible to promptly pay any additional balance due. An unpaid balance over 30 days past due may be referred to a collection agency.

Insurance: We encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitations, effective annual calendar renewal date or any pre-authorization requirements. Elite Physical Therapy cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. **Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.**

Cancellation Policy: Therapist time is reserved for your appointment-if you are unable to keep your appointment we kindly ask that you provide us with 24-hour advanced notice of cancellation. If you fail to cancel a scheduled appointment 24 hours in advance, or "no-show" an appointment, we reserve the right to assess a $80 cancellation fee.

I have read and understand the above Elite Physical Therapy Consent and Financial policy and agree to all terms.

_____ _____

Printed Patient Name Printed Name of Guarantor (if applicable)

_____ _____

Signature of Patient (or Guarantor) Date