

Consent and Financial Responsibility Policy



Consent to Treat & General Consents

- I consent to and hereby authorize Physical Therapy Solutions, through its appropriate personnel, to perform the evaluation, care, and treatment procedures deemed necessary by my referring provider and other healthcare providers. I understand that no warranties or guarantees have been made to me about the outcome of my Care. I understand that Physical Therapy Solutions may work with accredited academic institutions through clinical affiliations to provide healthcare professionals in training with patient care learning experiences. I further understand that such healthcare professionals in training may be involved in my Care.
- I understand that Physical Therapy Solutions will not be responsible for the loss, destruction, or theft of any of my personal property. I take full responsibility for and release Physical Therapy Solutions from any and all responsibility and/or liability for the loss, destruction, or theft of my personal property at or near the Physical Therapy Solutions clinic.
- I understand that I am not permitted to take pictures or make a video or audio recordings at the Physical Therapy Solutions clinic, my care, or other patients or personnel.
- I understand and acknowledge that Physical Therapy Solutions may lease or license real estate, equipment, or other personal property from third parties to perform the evaluation and treatment procedures deemed necessary by my physician and therapist to treat my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other people for whom I have requested such services, release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Leased Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law. This paragraph does not release any claims, demands, actions, and/or causes of action against Physical Therapy Solutions.
- I understand and consent that Physical Therapy Solutions may, from time to time, make calls and/or send text messages to any telephone number associated with my account, which could result in charges to me and/or the account holder. I understand and consent that the manner in which these calls or text messages are made may include, but is not limited to, the use of

prerecorded/artificial voice messages and/or automatic telephone dialing systems. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time. I understand and consent that Physical Therapy Solutions may send emails to me at any email address provided and/or use other electronic means of communication to the extent permitted by law. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time. I understand that phone calls between Physical Therapy Solutions personnel and me (or anyone I have authorized to speak on my behalf) may be monitored and/or recorded to ensure the quality of response to patient inquiries.

- I understand and acknowledge that my appointment times are scheduled per the availability of professional staff. I understand that Physical Therapy Solutions may reschedule my appointment if I arrive more than 15 minutes late. I also acknowledge that Physical Therapy Solutions requires 24 hours advance notice of cancellation and that Physical Therapy Solutions reserves the right to charge a \$25.00 cancellation fee if I fail to cancel an appointment at least 24 hours in advance.

Financial Responsibility Policy

The terms and conditions of this policy are established to provide clarity regarding financial responsibility and ensure stress-free health care possible. Below outlines information specific to all aspects of the financial responsibility associated with your recovery.

Physical Therapy Solutions is working with various regional and federal insurance companies to be contracted as an in-network provider.

Payment in full at the time of check-in is expected at all times. Physical Therapy Solutions will provide all records and assist with forms in order for the patient to submit a self-claim with insurance. All patients are encouraged to contact their insurance provider for verification or clarification of allowed benefits. Knowing your insurance benefits is your responsibility.

At any time, any account balance incurred with Physical Therapy Solutions is legally your responsibility. The adult, parent, or legal guardian accompanying a minor dependent is financially responsible for all services rendered by Physical Therapy Solutions and agrees to all terms listed herein.

Physical Therapy Solutions is currently accepting workers' compensation insurance carriers, personal injury insurance, and automobile insurance.

If Physical Therapy Solutions will be billing a workers' compensation carrier or motor vehicle insurance provider, it is imperative that we receive your claim information as quickly as possible. We will also require a copy of your personal insurance information in the event that your workers' compensation or motor vehicle accident claim is denied.

We will charge 6% financial charges for any outstanding balance after 60 days. Our policy is to report any delinquencies to the credit bureau past 90 days and send the outstanding balance for collection. If the account balance is sent to collection, any legal fees paid to secure overdue balances will be added to your account.

Terms of Agreement:

I, the undersigned, hereby agree with the following:

- All financial dues for the visit (co-pay, co-insurances, or self-pay) plus any accrued balance on my account must be paid at the time of service.
- I am aware that some, and perhaps all, of the services/equipment I have received may be non-covered, denied by my carrier, or not considered reasonable or necessary by Medicare or other providers. I understand that I am financially responsible for all charges not paid by my insurance company.
- I will present my ID and a copy of a current, valid insurance card to provide proof of my existing insurance coverage. I will notify Physical Therapy Solutions of any change in my information, including but not limited to address, phone number, or insurance coverage.
- My insurance company may need 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 certify that I (or my dependent) have insurance coverage as provided to Physical Therapy Solutions and assign all insurance benefits directly, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance provider. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I understand that I may be assessed a 6% monthly finance charge for balances accrued over 60 days. I understand that I may be assessed a full self-pay amount for the no-show appointments and \$35 for not canceling within 24 hours of my scheduled appointment time. These charges are my responsibility and are not covered by my insurance.

Please read carefully and sign where indicated. A copy of this form will be issued to you upon request.