ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES LLC

CONSENT TO TREAT/RELEASE OF INFORMATION/GUARANTEE OF ACCOUNT

1) **Authorization to Release Information:** I hereby authorize Orthopedic Physical Therapy Associates LLC to release to my insurance carrier(s) any information acquired during the course of my examination and treatment that is necessary to process my insurance claim.

2) **Authorization to Pay Benefits:** I hereby authorize payment directly to Orthopedic Physical Therapy Associates LLC for the medical/therapy benefits payable for services rendered.

3) **Consent to Treat:** I hereby authorize and consent to all physical therapy services performed by Orthopedic Physical Therapy Associates LLC. This includes communication with appropriate medical personnel.

4) **Financial Responsibility:** I understand that I am financially responsible for all charges incurred by myself. I understand that payment is due when services are rendered. Acceptable forms of payment include cash, check, debit or credit card. A medical insurance policy is a contract between you and your insurance company. As a courtesy to you, we will bill your insurance company in lieu of immediate payment. If for any reason, the insurance payment is delayed for 90 days after treatment, I will pay the bill in full. I further agree to pay interest on accounts past due over 30 days at a rate of 12% per year. In the event it becomes necessary to refer this account to collections, I agree to pay attorney fees and collection costs. I understand that I am responsible for paying any deductible or co-payment required by my insurance agreement on the date of service. Prior to beginning treatment, we will verify your insurance benefits. While we take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. Secondary insurance will be filed for you if all required information is provided.

5) **Medicare:** We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary for you, if you have one, or the balance will be billed to you.

6) **Worker's Compensation:** As an injured worker, I understand that my physical therapy will be covered by Worker's Compensation. However, if my claim is denied for any reason, I understand that I will be fully responsible for the total cost of my care.

7) **Self Pay:** Balance is due in full at the time of service. A 20% discount off of our fee schedule will be applied due to decreased administrative and filing costs. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements.

8) **Attendance:** Consistent attendance at your therapy appointments is crucial for optimal results. We request the courtesy of 24-hour notice for appointment cancellations if possible. Failure to notify us that you will not be attending a visit in this time frame will result in a $25.00 cancellation or no-show fee.

9) I understand that patients admitted to Orthopedic Physical Therapy Associates LLC are rendered services without distinction due to race, color, national origin, religion, sex, handicap or age. This facility complies fully with 1) Title VI of the Civil Rights Act of 1964, 2) Section 504 of the Rehabilitation Act of 1973 and 3) the Age Discrimination Act of 1975.

10) I have received a copy of the formal office HIPAA policy and procedures.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date