



Consent for Treatment & Office Policies

At ProAction Physical Therapy our patients are our priority. We hope that by providing you with this information, we can prevent misunderstandings and hope that you will feel comfortable discussing financial and insurance matters with us.

Financial Policy:

Our office will gladly assist you to determine your physical therapy insurance benefits, including co-insurance. If possible, we will verify your insurance benefits and eligibility, prior to your first appointment. We will advise you of your benefits if we are able to obtain them from your insurance carrier. It is the patient's responsibility to be aware of your own insurance's policies. Your insurance contract is between you and your insurance company. Any oral representation we make in good faith to you concerning your insurance is not binding on ProAction Physical Therapy and will not in any way or for any reason be considered a modification of this writing. Be aware that you are responsible for all account balances, even with insurance benefits. ProAction Physical Therapy contracts with The Provider Connection to process all claims. All eligible insurance will be billed for services that you are seen for in our office and only bill you for the patient portion of your services, based on your insurance determination. You are responsible for paying your co-payment, or co-insurance, at the time of each treatment. Please advise office staff of any address, phone, insurance, new injury, and/or employment changes, to ensure accurate billing. Please note that we do not accept third party claims or liens.

INSURANCE BENEFITS:	Patient Responsibility: Deductible: _____ Met? Yes <input type="checkbox"/> No <input type="checkbox"/> Remaining _____
	Co-Insurance: _____ % / _____ % Out of Pocket Max _____ Co-Pay: _____ per visit
	Verified By: _____ on Date: _____

Please note that billing your insurance is not a guarantee of payment.

Medicare Patients:

Medicare guidelines require that physical therapy patients see their physician every thirty days. If you wish to continue treatment you must make an appointment with them before the thirty days expires. If you should choose not to visit your physician, please be aware Medicare does not cover for this visit and that your supplemental insurances may not either. You will be responsible for paying the balance for the service in the case that your insurance(s) does not. If you should choose not to visit your physician, you will be asked to sign a Medicare waiver at the time of service. This waiver is an acknowledgement that you are aware Medicare does not cover for this visit and that your supplemental insurance(s) may not either and that you will be responsible for paying the balance. As of January 1, 2009, Medicare requires you to pay a \$135 annual deductible. After this deductible is met, you are responsible for a 20% co-insurance for each visit (amount may vary depending on what is performed during the session but, on average, it is somewhere between \$20-\$32). If you have a secondary insurance, no co-pay or co-insurance is typically required. Medicare has a maximum \$1840 "cap" per calendar year, that can be charged for combined physical therapy and speech-language pathology services (this is for ALL conditions during that year; and is equal to approximately 13-15 visits). When that amount has been reached, if you decide to continue receiving treatment, you are responsible for out-of pocket treatment costs. Some diagnoses allow us to request for an extension to this "cap". This extension is not guaranteed and only applies if further physical therapy is proven to be medically necessary to reach your functional goals.

Signature of Medicare Patient: _____

Cancelations and No Shows:

If you are unable to make your scheduled appointment, we ask for 24 hours notice so that we may be able to give your appointment time to another patient. **You will be billed a \$25 fee for not showing up to a scheduled appointment or cancelling with less than 24 hours notice.** We understand that emergencies or unforeseen illnesses occur, but we ask that you respect our policies and take responsibility if you forget your appointment. If a patient fails to appear without contacting us for three scheduled appointments or cancels an excessive number of times, physical therapy treatment may be discontinued and the referring physician(s) notified.

Payment:

All accounts not covered by insurance are due and payable in full at the time of service. We accept cash, credit cards, and checks. Checks returned from your bank for non-sufficient funds will be subject to a \$35 fee.

Release of Information and Benefit Assignment:

I assign all medical benefits to ProAction Physical Therapy including health insurance, Medicare, auto insurance, worker's compensation or other insurance plans. I authorize ProAction Physical Therapy to release all medical information and records necessary to secure payment for services rendered. A photocopy of this assignment is to be considered as valid as the original. I authorize my insurance benefits to be paid directly to ProAction Physical Therapy. If any payments of medical benefits are made directly to the patient for services rendered by ProAction Physical Therapy, I agree to promptly remit such payment directly to ProAction Physical Therapy. I am financially responsible for any balance due.

Authorization for Treatment of a Minor:

I authorize ProAction Physical Therapy to treat _____, the minor patient. I understand the parent or guardian accompanying a minor for treatment will be responsible for payment. If patient is a minor, and in the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by ProAction Physical Therapy to administer emergency care.

Signature of Parent/Guardian: _____

Patient Record of Disclosure of Protected Health Information:

The HIPPA privacy ruling gives patients the right to restrictions on the uses and disclosures of their protected information. In addition, the patient is provided the right to request that confidential communications or the communication of that protected health information take place by alternative means, such as sending correspondence to the individual's workplace instead of their home. The privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for protected health information to the minimum necessary to accomplish the intended purposes. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of disclosures that are made for reasons other than treatment, billing or healthcare operations. Information provided above, if completed properly, will constitute an adequate record.

Patient Consent:

I have read and understood the above mentioned and do hereby consent to evaluation and treatment by my physical therapist at ProAction Physical Therapy. I also acknowledge that I have received a copy of the Notice of Privacy Practices and I have been provided an opportunity to review the notice.

I agree to ProAction Physical Therapy's policies as described above.

Signature: _____ Date: _____

PATIENT OR GUARDIAN IF UNDER 18 YEARS OF AGE