



Patient Name: _____
Please print: First Name Middle Initial Last Name

CONSENT TO TREAT

I authorize the provider in charge of the care of the above named patient to provide diagnosis and treatment services.

Financial Responsibility: I agree to personally and fully responsible for payment for services rendered in accordance with my insurance benefits (e.g. co-pay, coinsurance) and for non-covered services. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney fees and collections expenses.

Assignment of Benefits: I request insurance payment for services rendered paid directly to Physio Pro PC.

I authorize the release of any medical information necessary to process payment for services rendered.

Signature Date

OUR FINANCIAL POLICY

Welcome to Physio Pro PC, we are committed to providing you with the best possible care. We shall strive to take care of you regardless of your or your family's financial needs. If you have medical insurance we will be glad to help you receive your maximum allowable benefits. If you do not have medical insurance, our staff will provide you with information regarding your options. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any non-emergent treatment.

- All patients must complete our "Patient Information Form" before seeing the therapist.
- Co-payments are to be made at the time of service.
- We accept cash, check, Visa, MasterCard and Discover
- Any checks that are returned due to non-sufficient funds are subject to a \$30.00 fee.

INSURANCE—PLEASE READ!!!

Your insurance is your responsibility. We will do our best to assist you; however, we cannot bill your insurance unless you bring in all of you insurance information including your identification card. You or your employer chose your insurance policy and it is a contract between you and your insurance company. We are not a party to that contract. Please be aware that in some cases, services provided may be "non-covered" services and may not be considered reasonable and necessary by your insurance company. We suggest that you review your policy in full so that you understand what services will be covered and those that you will be responsible for. If you have questions regarding your specific benefits, please contact either your insurance company or your Human Resources department. _____ Initial here

REFERRAL AUTHORIZATION

Do you have a valid *authorization number* from your primary care physician? Valid referrals are required at the time of service. If no referral is obtained before your visit, the insurance company may not pay for your visit. Referrals will not be given retroactively. Because of this policy made by your insurance company, you agree to comply with the following:

- Your referral must be brought with you at the time of your visit.
- You must obtain a referral from a primary care physician (PCP).

- We cannot bill your insurance company if you do not have a valid referral and the documentation of your referral at the time of your visit. You may be required to reschedule your visit or pre pay at the time of service.
- Verbal confirmation of a referral from your primary care physician's office at the time of your visit is not acceptable. Several insurance companies will not pay for services unless we have a "hard copy" of the referral. This can be a faxed copy of the original or a copy of your PCP's request to the insurance company. Our fax number is 303-370-2696.
- Patients without a referral at their scheduled visit, or without adequate insurance information, may be seen, if desired, on a fee-for-service basis. Payment must be made at the time of the visit.
- As always, Co-payments must be paid at the time of service.

Please ask if you have questions. Also, remember that your insurance company has made obtaining referrals your responsibility.

CO-PAY POLICY

I fully understand that it is the responsibility of the patient and/or guarantor to pay a co-pay (if your insurance requires one) at the time of service, per the PATIENT'S contractual agreement with their insurance company.

FINANCIAL HARDSHIP

If you are having financial difficulties, please do not hesitate to see us. We have options available to you including a sliding fee scale for qualified applicants. Please let us know of financial problems before you see the therapist so that arrangements can be made.

CANCELLATION AND NO-SHOW POLICY

It is the written policy of this office to accommodate our patients' needs and schedules to the best of our ability. For this reason, we ask our patients to please call us to cancel an appointment they cannot keep, even if only a few hours notice can be given. 24 hours notice is preferred since scheduling during the day is made difficult by late cancellations. **Excessive no shows and cancellations may result in discharge from our practice and/or notification to your insurance company of non-compliance.** Please help us serve you better by keeping scheduled appointments. Thank you in advance for your cooperation.

_____ Guarantor's Initials

I UNDERSTAND THAT:

- HMO and PPO insurance patients must make their co-payments at the time of service.
- A patient's insurance coverage is a contract between the patient and the insurance company to help the patient meet medical expenses. Because coverage varies so greatly and because of PPO & HMO regulations, it is not possible for Physio Pro PC to provide services on the basis that the insurer will always pay all charges. **READ YOUR SUBSCRIBER MANUAL CAREFULLY!**
- Any checks that are returned due to non-sufficient funds or due to stop payment will be subject to a \$30.00 fee that is payable by the patient.

I have read and thoroughly understand all pages of this financial agreement.

PRINT NAME

SIGNATURE

DATE

STAFF MEMBER'S SIGNATURE