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:

Your insurance contract is between you and your insurance company, therefore it is your responsibility to be aware of your own insurance's policies for physical therapy benefits. Any oral representation we make to you, concerning your insurance, is not binding on ProAction Physical Therapy and will not be considered a modification of this writing. If possible, we will verify and advise you of your insurance benefits and eligibility, prior to your first appointment. ProAction Physical Therapy contracts with a billing service to process all claims. All eligible insurance plans will be billed for services that you receive at ProAction Physical Therapy and only bill you for the patient responsibility of your services. Patients who wish to receive healthcare services from ProAction Physical Therapy and have their insurance company billed for those services are financially responsible for any co-payments, co-insurance and deductibles. The rules that govern payment for services are unique to each insurance payer, and some services received may not be covered by your specific insurance policy. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason why your doctor or physical therapist have recommended it. Your insurance company may add or change coverage policies, at will, that could affect their payment for your services received at ProAction Physical Therapy. You are also financially responsible for all **non-covered services**, including any service determined by your insurance company to be: "not covered", "not medically necessary", "not authorized", "patient share", "patient responsibility", "maintenance", "not supported by documentation" or otherwise deemed a non-payable benefit. This determination also includes any service for which your insurance company changes the number of units of service from that which was actually delivered to some other quantity. (Including, but not limited to CPT codes: 97001 through and including 97750) This includes determination of non-payment based on a post-service claims review basis, also known as retroactive denial. 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.

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

All visit co-payments and deductibles must be paid at the time of service.

Your signature on this form acknowledges that you agree to bear full financial responsibility for all possible non-covered services provided at ProAction Physical Therapy including, (but not limited to) manual therapy, passive modalities (such as electrical stimulation, ultrasound), taping, therapeutic exercise, therapeutic activities and/or neuromuscular reeducation. There may be additional items that you select to purchase at the time of service that your insurance does not cover, such as a foam roll or ice wrap.

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.

Parent/Guardian Initials: _____

Authorization for Treatment of a Minor:

I authorize ProAction Physical Therapy to treat _____, a 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: _____

Medicare Patients:

Medicare guidelines require that physical therapists must develop a plan of care (POC) for every Medicare patient, and a physician or nonphysician practitioner (NPP) must certify that POC within 30 days of the initial therapy visit. Recertification of POC is required every 90 days. Medicare does not require the patient to actually visit the certifying physician or NPP, although that physician or NPP may require a visit. Medicare requires you to pay an annual deductible of _____ for the year 20___. After this deductible is met, you are responsible for a 20% co-insurance for each visit (amount may vary, depending on what is billed each session). If you have a secondary insurance, no co-pay or co-insurance is typically required. Medicare has a calendar year maximum "cap" of _____ for 20___, combining charges for physical therapy and speech-language pathology services (this is for ALL conditions during that year). When that amount has been reached, if you decide to continue receiving treatment, you are responsible for out-of pocket treatment costs and will need to sign an Advanced Beneficiary Notice (ABN) to continue physical therapy services.

Signature of Medicare Patient: _____

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.

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.

Payment:

All accounts not covered by insurance are due and payable in full at the time of service. I understand that patient balances, not paid within 30 days, may incur a finance charge. Any additional fees incurred for collection services on unpaid balances greater than 90 days will be added to your account. We accept cash, credit cards, and checks. Checks returned from your bank for non-sufficient funds will be subject to a $35 fee.

Patient Consent:

I have read and understood the above mentioned and do hereby consent to evaluation and treatment by my physical and/or massage 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. **By my signature below I agree to be financially responsible for payment of all services received, regardless of insurance coverage.**

_____	_____	_____	_____
Patient or Responsible Party **Signature**	Patient or Responsible Party Name (PLEASE PRINT)	Relationship	Date