**Patient Agreement Form**

**Payments:**

Copays, coinsurance, deductibles, and payment for supplies are due at the time of service. Balances remaining after insurance payments are due within 30 days.

Any amount not covered or denied by your insurance company is your responsibility. If your insurance company has not made payment on your account within 90 days, you must pay your account in full or make arrangements for a payment plan. You may then contact your insurance company for reimbursement. Should your account be sent to collections, we reserve the right to charge interest on the overdue balance in the amount of 21% as approved by law.

**Insurance:**

Your insurance policy is a contract between you and your insurance company.It is your responsibility to know your visit limit for the enrollment year. Please call your insurance to find out how many visits you have available so you can keep track.

Your private insurance will NOT pay for the therapy if your therapy needs are due to a motor vehicle accident.

My therapy is related to injuries from a car accident. \_\_\_Yes \_\_\_No

**Medicare:** (skip this section if you don’t have Medicare)

Medicaredoes not provide outpatient physical therapy if you are having home care provided for any reason.

I am currently receiving home health care \_\_\_Yes \_\_\_No

I have had outpatient physical therapy in this calendar year. \_\_\_Yes \_\_\_No

**Cancellation Policy:**

Cancellations must be made at least 24 hours in advance of your appointment. Weather and emergencies are an exception. If the appointment is not cancelled 24 hours in advance, you will be responsible for a $20.00 charge.

**I authorize Physical Therapy to be provided by a licensed physical therapist.**

**I authorize South Valley Physical Therapy to bill and receive my health insurance benefits and to provide the information necessary to process medical claims.**

**I understand and agree to this Financial Policy.**

**PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**