Dear Patient,

Thank you for choosing *Doctors of Physical Therapy* for your rehabilitation needs. We are committed to providing quality care and service to our patients. We hope your experience in our facilities exceeds your expectations! The below document outlines some of our company policies. We highly recommend you take the time to read this document in its entirety and ask a member of our team to clarify any questions before signing the acknowledgment page.

Financial Policy

A part of our commitment of service to you is to educate ourselves on your insurance benefits. However, your insurance is a contract between you and/or your employer and the insurance company. We are not a party to that contract. As a courtesy to you, we will bill your insurance company, if we are provided correct and accurate information.

Your insurance carrier has stated to our staff that the information we received is not a guarantee of payment, but considered a quote of benefits. Your insurance company will determine your benefits when they receive and process your claims. Once your claims are processed, an explanation of benefits will be communicated to both you and our facility.

The verification listed below indicates your responsibility for deductibles, co-payments, and/or co-insurance. **If you feel the information listed below is incorrect, please notify the front desk immediately. Alternate payment options may be available by contacting a member of our billing team at (630) 434-0271 x224.**

Quote of Benefits

(This Information Will Be Completed By the Doctors of Physical Therapy Staff)

Primary Insurance Carrier:	
Co-Pay: $	**Payment Due In Full at the Time of Service**
Co-Insurance: $ **Co-Insurance %:**	**Estimated Payment Due at the Time of Service***
Deductible: $	**Estimated Payment Due at the Time of Service****
Deductible Met To Date:	**Date of Quote:**

* Co-Insurance estimated payments are based on our average visit charges of $100.00/ visit. The remainder of your service will be billed to you. Payments are due at the time of service.

** Policies with deductibles over $500.00 per calendar year will be charged $75.00 per visit. The remainders of your service charges will be billed to you. Payments are due at the time of service.

Consent to Treat:

I hereby grant my permission to the staff of *Doctors of Physical Therapy* to perform the procedures as prescribed by my physician. I have been informed of and understand the nature of the procedures that will be performed on me.

If I would become ill while undergoing treatment by *Doctors of Physical Therapy* staff, I give the staff permission to administer that treatment which they consider necessary to my well-being and only limited to physical therapy practice. My signature of mark below indicates that I understand and agree to the above-stated information.

Release of Medical Information and Authorization to Pay Insurance Benefits:

I authorize *Doctors of Physical Therapy* to release information from my medical record to my insurance carrier(s), or government agencies for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of benefits applicable to the services and pay all assigned insurance benefits directly to *Doctors of Physical Therapy* on my behalf.

Medicare Certification:

I certify that the information given by me in applying for the payment under title XVIII of the Social Security Act is correct. I authorize *Doctors of Physical Therapy* to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers for the processing of claims for medical benefits. I request that payment of authorization benefits be made directly to *Doctors of Physical Therapy*, on my behalf.

Cancellation Policy:

In order to better serve our patients and ensure we are providing an exceptional experience, we require the following:

1. 24 hour notice of any scheduled appointment, including rescheduling or cancellation. Failure to provide 24 hour notice may result in charges.
2. Patients arriving more than 15 minutes after the starting time of their appointment may be asked to reschedule. Please provide us with advanced notice if you will be running late.
3. Patients that do not show up for their scheduled appointments and give no advanced notice may be subject to full charges. Patients that do not show up for three consecutive treatments without notice will be automatically discharged.

Privacy Policy:

I acknowledge that I have received and fully understand the *Doctors of Physical Therapy* Notice of Privacy Practices. I also understand that a copy of the Privacy Practices is available upon request.

Acknowledgement Page

I, ____, have read and understand the above *Doctors of Physical Therapy* policies including:

- Financial Policy
- Consent To Treat
- Release of Medical Information
- Medicare Certification (if applicable)
- Cancellation Policy
- Privacy Policy

With my signature below, I agree to the terms and conditions set forth by *Doctors of Physical Therapy* for payment, services, and treatment as provided in this document.

____ _____________

Patient Signature Date

____

Printed Name

Received By:

____

Team Member Name