1501 Lower State Rd Ste 308 North Wales, PA 19454
Phone (215) 997-9898 Fax (215) 997-9899
www.totalperformancept.com

Patient Authorization and Guarantee

CONSENT OF TREATMENT

I hereby consent to all treatment procedures and patient care deemed necessary by my physical therapist while I am a patient of Total Performance Physical Therapy, Inc.

PAYMENT AUTHORIZATION

I hereby authorize that the payment of authorized benefits be made directly to Total Performance Physical Therapy, Inc. for any services that are reimbursable by Medicare, Medicaid or any third party sources.

NON-DISCRIMINATION

Total Performance Physical Therapy, Inc and the patient agree that services will be rendered to each individual regardless of race, color, sex, age, national origin or handicap.

AUTHORIZATION OF PHONE CONTACT

I hereby authorize the staff of Total Performance Physical Therapy, Inc. to leave messages on my answering machine/voice mail pertaining to insurance information, confirmation of appointments or the need for future scheduling. I also allow the staff to leave these messages with a family member.

_____ _____

Signature Date

VALUABLES

Total Performance Physical Therapy Inc. is not responsible for any personal property or valuables brought into the facility.

CHILD PLAY FACILITIES

Total Performance Physical Therapy Inc. assumes no responsibility or liability for any harm or injury sustained by any child left in the child play facilities. While we welcome you bringing your child, it is your responsibility to supervise your child and maintain his/her safety. This area will not be supervised.

MEDICARE

I hereby certify that all information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

CANCELLATION POLICY

At Total Performance Physical Therapy, we want to make sure that you succeed at restoring your function. We strive to provide superior care in order to make that happen. However, it takes consistent participation in your program to truly see results. Cancellations and no-shows can make or break your success with physical therapy.

When you cancel/no show for an appointment it affects 3 people: 1. You the patient – you may not reach your desired physical therapy outcomes without regular attendance, 2. The physical therapist – who kept that appointment time open for you 3. Another patient – who would have taken advantage of your time slot. Due to the hands on nature of the clinic and the private nature of the pool, you not showing up for your appointment or canceling at the last minute means others who were in need of that time had to make other arrangements for their therapy.

Therefore we require 24 hours advance notice for cancellation of all appointments. If we are not here, a message may be left on the machine or an email may be sent. If we are not provided a minimum of 24 hours notice prior to cancellation or it is a

_____ _____

Signature Date

no-show a $20.00 fee will be assessed to your account. This fee will not be covered by your insurance company and will be due upon your next visit.

FINANCIAL POLICIES

All co-payments are due at the time of services rendered. Cash, check, debit, MasterCard, Discover and Visa will be accepted.

Any past balances must be paid in full before returning to our facility for future treatment.

Balances remaining after 60 days, which are not being actively paid on, are subject to a 1.5% interest charge per month. All balances not being actively paid on will be sent to a collections agency at 90 days. Upon submission to a collection agency it will be the patient or guarantors responsibility to pay all collection and legal fees incurred by our office while collecting the outstanding balance.

I understand that there may be supplies used during my treatment that may not be covered by my insurance company. While we will do everything to advise you of these ahead of time but it is ultimately your financial responsibility.

Your insurance is a contract between you, your employer (if applicable) and your insurance company. While we provide services for your insurance company, we are not party to that contract. While Total Performance Physical Therapy Inc will do its best to obtain insurance coverage information; it is ultimately your responsibility to understand your insurance benefits, limitation and payments.
I will notify Total Performance Physical Therapy Inc of any changes to my insurance during my treatment.

All co-insurances will be billed to you by our office following treatment. We will collect a $10.00 payment each visit for a 10% coinsurance and a $20.00 payment each visit for a 20% coinsurance.

For patients with a deductible, we will be collecting a minimum of a $25.00 payment each visit.

If we do not participate with your insurance company, payment is due in full at the beginning of the visit. We will be happy to provide you with an itemized bill for you to be able to submit to your insurance company.

In auto accident cases, we accept Personal Injury Protection (PIP). It is your responsibility to provide us with this information and your and your attorney's signature.

_____ _____

Signature Date

After PIP has exhausted, it is you are responsible for any remaining balance. If another insurance company will cover the balance it is your responsibility to provide us with all the necessary information to pursue reimbursement.

If your Worker's Compensation Claim is denied, we expect payment in full within 30 days. If there are other insurance companies that may be billed it is your responsibility to provide us with this information. We will pursue reimbursement from these sources, however, if denied, it will ultimately be your responsibility.

We must emphasize that our relationship is with you the patient, not the insurance company. And while we pursue reimbursement through your insurance company the charges incurred on each date of service are ultimately your responsibility. If you encounter financial hardship it is your responsibility to contact our office and make payment arrangements.

I, _____, have read and understand all guarantees and financial policies above.

_____ _____

Signature Date

_____ _____

Witness Signature Date

_____ _____

Signature Date