



FINANCIAL AGREEMENT

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me, instead of Restore Physical Therapy, I will immediately deliver such payment directly to Restore Physical Therapy. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. There will be a 1.5% late charge of any balance 90 days or over; once the insurance company pays. *Please initial* _____.

I hereby give authorization for payment of insurance benefits to be made directly to Restore Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

Signature (Parent or guardian signature if patient is a minor)

Date ____/____/____

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective.

APPOINTMENTS

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation. We require advance notice of 24 hours of cancellation. Failure to show for an appointment or cancellation without sufficient notice may be subject to a \$25.00 charge.

CO-PAYMENT POLICY

Patients that carry health care insurance should remember that some policies require a copayment for each visit. Consequently it is your responsibility as defined by your policy to make these copayments. Also important is that you are responsible for any and all supplies, such as braces and exercise equipment, which are provided to you and are not covered by your particular plan. I understand and agree that I am solely responsible for all copayments and charges incurred which are not covered under my health care plan. I also authorize the release of any medical information necessary to process this claim.

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment of the above named patient at Restore Physical Therapy. I realize that I am an integral part of the rehabilitation process and will be sufficiently educated about treatment and alternatives before they are performed. *Please initial* _____.

Signature (Parent or guardian signature if patient is a minor)

Date ____/____/____

Patient Name : _____