Physical Therapy ONE
Registration Form for Returning Patients

CONSENT FOR TREATMENT: I hereby agree to have a licensed Physical therapist perform an evaluation and render appropriate treatment ordered by my physician. I also authorize the release of any information pertinent regarding my case to any Insurance company, adjuster, or attorney involved in the case. I direct the insurer to directly pay, without equivocation, Physical Therapy ONE all benefits due them and guarantee payment for services.

CANCELLATION POLICY: Physical Therapy ONE requires 24-hour notice for any cancellation. A **$50.00** fee will be charged to your account for non-compliance, including not showing for your appointment. More than 3 (three) cancellations/no-shows will result in an automatic discharge.

HIPAA Information + (Please initial)

I was offered a copy of the Notice of Privacy Practices _________

I agree to release medical or other information to process claim _________

I agree to accept assignment of payment _________

I give the office permission to leave a message _________

FINANCIAL AND BILLING POLICY

We will bill your insurance for you, but you should be aware of the following information:

BILLING YOUR INSURANCE: As a service to our patients, our office will bill your insurance carrier. The final responsibility for the entire balance belongs with you, the patient. You will be expected to pay for any charges that are not covered by your insurance, such as supplies, office visits, co-pays, deductibles or balances left from an insurance payment. Payment will be expected from you after 30 days from the date of billing. It is up to you to contact your insurance carrier regarding any problems or delays you might be experiencing with your claims, although we would be happy to address any questions that you have. We accept MASTER CARD AND VISA PAYMENTS, CASH OR CHECKS. We can also set up payment arrangements. **If we receive your check back from the band for insufficient funds, you will be charged a $25.00 fee.**

COURTESY CLIAM FILING: It is the patient's responsibility to guarantee payment for physical therapy services at Physical Therapy ONE. As a courtesy, Physical Therapy ONE will file with your primary and/or secondary health insurance ONE TIME ONLY per visit. You will be responsible for any charges that have been denied by your insurance company. We will provide any necessary information to assist in this filing process.

IF WE DO NOT PARTICIPATE WITH your insurance, we will still bill your carrier for you. However, you are responsible for the amount not covered by your insurance carrier.

REFERRALS OR AUTHORIZATIONS If your insurance carrier requires a referral or authorization, these usually come from your primary care physician. Please make sure that this is in place BEFORE services are provided. If proper authorization is not obtained, you may be responsible for your entire balance.

LEGAL ACTIONS FOR PERSONAL INJURY if you are involved with legal action for personal injury, we do not accept this as a reason to delay payment for our services. Responsibilities of payment belong to the patient. We are happy to provide your attorney any information they request with a signed release from you and at a fee they will be required to pay for such records.

Please sign and date below that you accept and understand our financial and billing policy, HIPAA, consent for treatment and cancellation policy:

Sign Here ____ Date ______________________

Print Name____

Responsible Party if other than patient ______________________________ Relationship _________________

PHYSICAL THERAPY ONE
FINANCIAL AND INSURANCE BILLING POLICY

PHYSICAL THERAPY ONE will bill your insurance for you, but you should be aware of the following information:

BILLING YOUR INSURANCE: As a service to our patients, our office will bill your insurance carrier. The final responsibility for the entire balance belongs with you, the patient. You will be expected to pay for any charges that are not covered by your insurance, such as supplies, office visits, co-pays, deductibles or balances left from an insurance payment. Payment will be expected from you after 30 days from the date of billing. It is up to you to contact your insurance carrier regarding any problems or delays you might be experiencing with your claims, although we would be happy to address any questions that you have. We accept MASTER CARD, VISA, AND DISCOVER PAYMENTS, CASH OR CHECKS. We can also set up payment arrangements. **If we receive your check back from the bank for insufficient funds, you will be charged a $25.00 fee. If your account was to be sent to collections, you will be responsible for any additional fees incurred.**

What does "PARTICIPATE WITH INSURANCE" mean?
WE PARTICIPATE WITH select insurance companies. In most cases this means that we accept the amount that the insurance carrier pays as full payment for our services. You remain responsible for co-pays or deductibles even if we participate with your insurance carrier. We encourage you to contact your insurance carrier to verify your physical therapy benefits.

IF WE DO NOT PARTICIPATE WITH your insurance, we will still bill your carrier for you. However you are responsible for the amount not covered by your insurance carrier.

REFERRALS OR AUTHORIZATIONS If your insurance carrier requires a referral or authorization, these usually come from your primary care physician. Please make sure that this is in place BEFORE services are provided. If proper authorization is not obtained, you may be responsible for your entire balance.

LEGAL ACTIONS FOR PERSONAL INJURY if you are involved with legal action for personal injury, we do not accept this as a reason to delay payment for our services. Responsibilities of payment belong to the patient. We are happy to provide your attorney any information they request with a signed release from you and at a fee they will be required to pay for such records.

Please sign and date below that you accept and understand our financial and billing policy:

Patient	Responsible Party if different than patient	Date