



Welcome!

SM

Your Treatment/Fitness Plan: This plan is based on your medical or fitness needs as determined by your diagnosis, your doctor's prescription, the physical therapist's evaluation, and your goals, as appropriate. (Check the box below and fill in patient name, as appropriate.)

→ *I agree and give my consent for Central Physical Therapy and Fitness, Inc. (CPTF) to furnish medical care and treatment considered necessary and proper in diagnosing or treating:*

- my physical condition and/or to provide fitness consultation and services for me.*
- _____ *physical condition and/or to provide fitness services for _____.*

Appointments: Your appointment time is reserved for you. Please contact us as soon as possible if you are unable to keep your appointment, so that we may offer your time to someone else. The following fee policy applies to cancellations without 24-hour notice and missed appointments. Please note that these costs are not covered by your insurance & must be paid prior to your next visit.

- First late cancel - \$15
- 2nd - \$30
- Others - \$50
- First missed appointment - \$30
- 2nd - \$60
- 3rd - \$75 and we will assume discharge

→ **Privacy Practices:** *I have read CPTF's Notice of Privacy Practices and understand that I have a right to a paper copy of this Notice.*

Financial Policy: It is our goal for you to clearly understand your treatment/fitness plan, as well as your financial responsibility before your program begins. Please read our complete financial policy on the reverse of this page before signing this document.

Insurance Benefits/Release of Information: As part of the financial arrangement process, we will prepare an estimate of your charges based on the clinical plan of treatment, including an estimate of the portion covered by your specific insurance plan. This is an estimate only. Actual charges will be based on your treatment and progress and payment by your insurance company is your responsibility. We will help in every way possible with the filing of your claim and the handling of insurance questions you might have.

→ *I authorize my insurance benefits to be paid directly to Central Physical Therapy and Fitness, Inc.. I agree to release any information necessary to process claims.*

→ **Your responsibility:** *I agree that I am financially responsible for all co-payments, deductibles, and non-covered services as determined by my insurance plan at the time of claims processing. I am aware past due accounts will be subject to a charge of 1 % per month interest and returned checks will result in a \$30 fee. I am responsible for all collection costs incurred by Central Physical Therapy and Fitness, Inc. should my account remain unpaid. I have read the complete CPTF Financial Policy on the reverse of this page.*

A copy of this form shall be as valid as the original.

Client/Legal Guardian Signature: _____ **Date:** _____

Legal Guardian's Relationship to client: _____

Central Physical Therapy and Fitness, Inc. Financial Policy

ALL PATIENTS/CLIENTS:

Statements/Service Charges

We will send you a statement monthly. A service charge of 1 % per month will be added to all account balances over 60 days past due. Returned checks will result in a \$30 fee.

Methods of Payment

We accept cash, checks, credit cards, and money orders. Credit card payments may also be made via our website.

PATIENTS WITHOUT INSURANCE AND FITNESS CLIENTS:

Terms of Payment and Billing Policy

Payment arrangements must be made prior to your first visit. Payment is expected at time of visit unless prior payment arrangements have been made.

PATIENTS WITH INSURANCE:

Terms of Payment and Billing Policy

We will submit a claim to your insurance company on your behalf. All co-payments are due at the time of service. Payment from your insurance company will be made directly to us. Your portion of the bill (deductibles, non-covered services, and balances owed) is due as indicated on the CPTF statement mailed to you.

Remember, a health insurance policy is a contract between you and your insurance company. Payment for our service is ultimately your responsibility. We do not accept the responsibility for collecting an insurance claim or negotiating a disputed claim with your insurance company. We will help in every way possible with the filing of your claim and the handling of insurance questions you might have, but we strongly recommend that you call your insurance company before you begin treatment to verify your physical therapy benefits. Due to widely varying coverage, there may be a dollar and/or visit limit, pre-authorization or referral requirements or other restrictions.

Industrial Accident Claims

Please give us your claim number and employer information. For "open" claims, your bill is usually paid by L&I or your self-insured employer. If your claim is closed, denied or rejected, contact our office immediately to make other arrangements, as you are responsible for your bill.

Automobile Accident Claims

We will bill the appropriate insurance carrier based on the information received at the time of pre-registration. You are responsible for submitting all required Personal Injury Protection (PIP) and subrogation paperwork to your insurance carrier(s) within 30 days.

Medicare Claims

Medicare usually pays 80% of the claim after satisfaction of your annual deductible. You are responsible for the deductible and 20% of each claim. Please provide your secondary insurance information at the time of your first visit, if applicable. We will then submit a claim for the balance owed after we receive Medicare's payment.

DSHS Claims

You are required to present your ProviderOne ID at your first visit. DSHS usually allows 6 visits per calendar year. Authorization for additional treatment is granted on a limited basis and must be requested and received prior to any visits beyond 6. Please let us know if you have received physical therapy treatment this year prior to seeing us.