Active Solutions Physical Therapy
Consent and Payment Policy

PATIENT NAME: _____

PATIENT CONSENT:
I request services from Active Solutions Physical Therapy and its staff and consent to such treatment as ordered by my attending physician. I understand that my care is directed and monitored by the attending physician and that Active Solutions Physical Therapy and its therapists are not liable for any act or omission when following the instructions of said physician, who is neither the employee nor agent of Active Solutions Physical Therapy.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____
(If patient under 18 yrs.)

It is the policy of Active Solutions Physical Therapy that payment be received at the time of service. We require that all patients pay their deductible, co-pay and/or co-insurance payment at the beginning of each appointment. Any co-insurance payment will be based on the average cost of a physical therapy visit which is $100. Therefore, if you have an 80/20 you are responsible for $20 each visit. If you have a 70/30 then you are responsible for $30 per visit. When therapy is completed you may be billed for any outstanding balances or provided a refund if there is a positive balance.

If you are covered by health insurance for physical therapy, please provide your insurance information. We will verify your insurance as a courtesy, but we ask that you also contact your insurance carrier to confirm your coverage for physical therapy services. Being referred by a physician to our clinic does not guarantee coverage nor does verification of your benefits guarantee payment by your insurance carrier. **Please remember that you are responsible for all charges incurred.**

Please check your payment method and sign below that you have read, understand and agree with the information provided here on this page.

_____**Private Health Insurance (PPO):** Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility (deductible or amount paid by the patient before the insurance policy begins paying for services) and/or co-pay (set dollar amount per visit) or coinsurance (percent of the allowed charges). **Deductibles, copay and coinsurances are due at the time of service.** Should your insurance deny payment for services you will be billed for the outstanding amount.

_____**HMO:** Authorization from your insurance must be obtained prior to treatment. **Any copay or coinsurance is due at the time of treatment.** If your HMO plan also has a Point of Service option, you are using please be sure you understand the difference between the two coverage options.

_____**Medicare:** Active Solutions Physical Therapy is a certified Medicare provider. Medi-Gap insurance covers the amount due by the patient until your Medicare benefits are exhausted. Some secondary insurance plans cover services after Medicare benefits are exhausted but not all. All Medicare covered patients are subject to an annual deductible and a cap on physical therapy benefits. Some exceptions are allowed for medically necessary outpatient services.

_____**Secondary Medicare Insurance: _____**

_____**No Insurance (Cash):** If you do not have insurance you may be eligible for a discount. Cash payment is required before each visit.

_____**Worker's Compensation Claims:** Authorization from you insurance adjuster is required before you can begin treatment. Please provide the name and phone number of your adjuster, the date and nature of your injury and your claim number.

Cancellation Policy

Attending scheduled appointments is an important part of the treatment process and timely arrival allows for a full treatment session. If you are unable to attend your scheduled appointment, please notify the office at least 24 hours in advance. If 24-hour notice is not received, then a **$40** cancellation fee will be billed directly to the patient for each cancellation.

Signing below acknowledges that you have read, understand and agree to the cancellation policy and that all patient information provided is correct to the best of your knowledge.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____
(If patient under 18 yrs.)

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