FOCUS PHYSICAL THERAPY
FINANCIAL & PRACTICE POLICIES

Focus Physical Therapy is dedicated to providing the very highest level of physical therapy care and services to our patients. As a courtesy we will bill your insurance company in a timely manner and provide them with everything that is needed to process your claims and to try every possible means to receive payment from your insurance company. ***PLEASE INITIAL EACH PARAGRAPH BELOW:***

- _____ **I am ultimately financially responsible** for the professional services that I am about to receive. I promise to pay for these charges in a timely manner, but **if** in fact, the insurance company does not pay that I will be personally responsible for any usual, customary, or reasonable balance that may exist.
- _____ I understand that it is **my responsibility to understand my insurance coverage** as it relates to the services I am about to receive. I understand that my insurance company has provided a toll-free phone number on my insurance card that I can call at any time to ask any questions regarding coverage, eligibility, exclusions, deductibles, co-pays and any other inquiry I may have. I understand that **Focus Physical Therapy** in no way has any power to dictate policy or procedure of my own insurance company.
- _____ I understand that **my insurance company** decides what to reimburse **Focus Physical Therapy** only after bills are submitted and reviewed. **Focus Physical Therapy** has no authority or ability to decide what treatments will/will not be paid nor at what price. Only my insurance company knows this information once the bills are submitted.
- _____ I understand that if **I have chosen to purchase an insurance policy with a large deductible**, **Focus Physical Therapy** was in no way a part of that decision and cannot be expected to offer discounts of this predictable and personal financial decision. I understand that if my deductible is not met at the time it is verified then I am required to pay cash pay rates ($150 initial evaluation or $100 an office visit) until my deductible has been met. (Cash pay rates may be adjusted to allowed amounts depending on Insurance Carrier). I understand that ALL co-pays and co-insurances still must be paid at time of services.
- _____ I understand that if I **NO SHOW or CANCEL my appointment** without 24 hours notice, I am subject to a **$50 CHARGE.** This will be due at my next appointment. There is an answering machine available for my convenience 24 hours a day. In the event of consistent no shows and cancellations my future appointments are subject to cancellation by us and notification to my doctor, insurance company or adjuster.
- _____ I understand that **should I fail to pay** and am sent to collections, I will be responsible for all costs incurred including the balance that is due. (All balances due, must be cleared to return as a patient, unless arrangements have been made.)
- _____ I understand that if **I am financially responsible for a patient that is a minor** that I am required to keep a credit card/ check card on file to be charged for all co-pays, co-insurances and deductibles.
- _____ I understand that if I am a patient and need to bring a minor with me, that I am responsible for the minors behavior & safety. **Focus Physical Therapy** is in no way liable for any injuries incurred while at **Focus Physical Therapy**. We do not encourage bringing children to treatment as it can interfere with your treatment time and the treatment of other patients. Should your child be disruptive to the office in any way you may be asked to not bring them back to treatment. We also ask that other people accompanying you wait in the reception area, unless they are involved in your treatment.

Assignment of Benefits/ HIPAA/ Policy Agreement

I acknowledge that Focus Physical Therapy has supplied me with a copy of their Office Policies and Health Information Privacy Practice Agreement (HIPPA) regarding their policies and procedures concerning my Private Health Information (PHI). I agree to release authorization to Hands On Physical Therapy/ Focus Physical Therapy to use my PHI as deemed necessary for treatment, billing and the purposes mentioned in the notice. I hereby authorize my insurance benefits to be paid directly to Hands On Physical Therapy Inc./ Focus Physical Therapy. I also authorize HOPT/FPT to release any necessary information to process this claim. I have read and I agree with the above policies.

Patient or Responsible Party Signature _____ Date _____