



PATIENT CONSENT FORM AND EXPLANATION OF FINANCIAL TERMS

Welcome to ProAction Physical Therapy. Your insurance carrier may require that treatment be rendered only upon referral by a physician or podiatrist. This referral should be provided to us at your initial visit (evaluation). Referrals are generally valid for one month unless otherwise stated.

APPOINTMENT INFORMATION:

The initial appointment will usually last 45 to 60 minutes and all subsequent appointments lasting approximately 45 minutes. Please arrive promptly. If you are more than 10 minutes late, your therapist's schedule may prevent you from being seen. **In the event that you are unable to attend your appointment, we require at least 24 hours advance notice. There is a \$60.00 missed visit fee for failure to comply.** We reserve the right to cancel all subsequent visits if you fail to show up for any two visits.

BILLING INFORMATION:

• **Insurance coverage:** Please verify your insurance coverage with us at the time of your initial visit. ProAction Physical Therapy is a participating provider with Medicare and with most plans of Blue Cross Blue Shield (BCBS). For all other insurance carriers, ProAction Physical Therapy is considered an out-of-network provider of outpatient physical therapy services. For your convenience, we will attempt to contact your insurance company to verify your benefits at our clinic prior to your initial visit. However, there is no guarantee of payment from your insurance company. Please direct any inquiries about your coverage to your insurance company. For your convenience, we will submit your claim forms to your insurance carrier for you. Co-payment, co-insurance, and any deductible owed are expected at each time of service. _____ **initial**

• **Copay/Coinsurance/deductible collection:** For all out-of-network plans including Blue Choice HMO with out of network benefits, at each time of service we will collect an estimate of the expected co-insurance amount after the deductible is collected and met. For those patients with copayments, those copayments will be collected at each time of service. Patients having insurance coverage with which we are not filing, or those without physical therapy insurance coverage, are responsible for payment of treatment at each time of service. _____ **initial**

Any fees that are deemed 'patient responsibility' by your insurance carrier are considered your responsibility. ProAction Physical Therapy has the right to bill you for any balance remaining after co-insurance and deductibles are collected and you will be billed accordingly. _____ **initial**

AGREEMENT FOR PAYMENT OF SERVICES:

By signing this Agreement, you are accepting responsibility for payment of treatment rendered. If payment is not made and additional collection efforts are required, you agree to pay all bills rendered for treatment together with all collection costs, interest fees, and reasonable attorney's fees of 35% of the balance due. All bills are payable and become due upon presentation.

Your unpaid balances of fees are subject to Finance Charges at an annual percentage rate of eighteen percent (18%) per annum, which corresponds to a monthly periodic rate of 1.5%.

ACKNOWLEDGEMENT

I have read and understood all of the above information contained in this Agreement, and agree to abide by all of its terms. I further acknowledge that I am either the patient or have been duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

I consent to the procedures which may be performed at my physical therapy evaluation and during the duration of this treatment. I understand that it is ultimately my responsibility to pay ProAction Physical Therapy for all services provided and to assure that my insurance carrier properly processes my claims.

Signature

Date

AUTHORIZATION FOR DIRECT PAYMENT AND RELEASE OF RECORDS:

I hereby authorize ProAction Physical Therapy to apply for benefits on my behalf for services rendered by them. I request payments from my insurance carrier be made directly to ProAction Physical Therapy. I also authorize ProAction Physical Therapy, at its option, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. I authorize ProAction Physical Therapy to furnish medical records information in its possession relative to my diagnosis, treatment, and account status to other treating physicians, healthcare providers, and my insurance carrier(s) and their agents.

Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

If patient is 18 years old or older, please fill in and sign below:

I, _____, have received and understand the Notice of Privacy Practices.

Patient's Signature

Date

OR

If patient is UNDER 18 years old, parent/legal guardian must sign below:

I, _____, the parent/legal guardian of _____, have received and understand the Notice of Privacy Practices.

Parent/Legal Guardian Signature

Date