Name:___________________________ Today's Date: __________

Paso Robles Physical Therapy Statement of Office Policies

Welcome to Paso Robles Physical Therapy! We are pleased that you have chosen us for your rehabilitation needs. Please read this form in its entirety, *initial each point to indicate your acknowledgment,* and sign where indicated. The staff and management of PRPT promise to:

- *o Welcome you to a caring and professional environment where you will receive the best standard of care at all times.*
- *o Provide you with an individually designed treatment plan to meet your specific needs and goals.*
- *o Do our best to respect your time by staying on schedule, as well as respecting your privacy and dignity during treatment sessions.*
- *o Make no charges for appointment changes or cancellations where 24 hours notice given.*
- *o Request authorization for services rendered, (when required) in a timely manner.*
- *o Provide you with flexible payment options in order to insure continued access to quality treatment.*
- *o Provide you with a dedicated Patient Account Representative who is available to assist you with insurance and payment concerns.*

We appreciate your commitment to:

_____ Being an active participant in your physical therapy treatment by arriving on time for appointments, informing your clinician of any concerns or questions you may have, and complying with home exercise instructions or other recommendations.

_____ Notifying us by phone 24 hours in advance if you must cancel or change an appointment. A **$50.00** fee will result when 24 hour advance notification is not given. This fee is **not** billable to insurance and must be paid prior to receiving any further services. This fee does not apply to workers compensation patients, however the adjuster will be informed of any missed appointments which may result in the denial of additional visits.

_____ Paying co-payments, where applicable, at the time you are invoiced. Patients without insurance are asked to pay in full at the time of each appointment. We accept VISA, MasterCard, and checks.There will be a $20.00 fee imposed for all returned checks.

_____ Knowing the provisions and limitations of your insurance coverage; and understanding that your policy is a contract between you and your insurance carrier.

_____ Understanding that your treatment plan is based on medical necessity as determined by your referring physician and/or PRPT, not the limitations of your insurance policy; and requesting alternate treatment or payment arrangements if necessary.

_____ Providing us with accurate insurance information and the cause of your condition at the start of each episode of care, immediately upon changing insurance carriers, and/or when a new injury occurs.

_____ Paying balance from current invoice within 30 days. And, paying any balance due on your account over 60 days past due regardless of insurance reimbursement status.

_____ Understanding that balances over 90 days past due will be suspended for treatment unless a payment plan is established. *Any accounts over 120 days past due may be referred to a collection agency.*

Authorization and Assignment

I hereby authorize PRPT to release information necessary to my insurance company in order to process claims for charges incurred by me, and I release PRPT of any consequence thereof. In consideration of the services rendered to me by PRPT, I authorize and direct my insurance carrier to remit payment directly to PRPT.

Signature: ____ Date:___________

Name:____________________________ Today's Date: __________

Statement of Office Policies Cont'd.

Additional person with whom we may discuss your medical treatment, insurance, and billing details (such as a spouse, partner, caregiver, lawyer, or adult child)

Name: ____________________________________ Best phone #: ________________________

Additional person/entity with whom we may discuss appointment times:

[ ] Transit service: _________________________

[ ] Interpreter service: _____________________________

Consent to the Treatment of a Minor Child

Re: ____ *(Name of Minor Child)* DOB: ____/____/____

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for Paso Robles Physical Therapy to provide physical therapy treatment to said child. In an emergency, it is understood that authorization is granted to Paso Robles Physical Therapy to provide first aid and/or to notify Emergency Medical Services of the need for intervention. I acknowledge that I am responsible for any portion of charges that are not covered by insurance. This consent form will remain in effect until revoked in writing by me.

Parent / Legal Guardian Signature: ____

Printed Name: ____

Informed Consent for Telehealth Services

Telehealth is a means of treatment through live audio-visual two-way communication. Telehealth is decided as a viable treatment option if deemed appropriate by myself and my physical therapist. I realize that telehealth is treated as a normal visit and billed to my insurance as such. I agree to treat telehealth visits as a normal visit that may include; consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. My signature below authorizes my consent to participate in Telehealth services.

Signature ____

Direct Access Informed Consent

This is a notice for our patients electing for self-referral or "direct access" to physical therapy treatment in the state of California. Per state law we are required to inform you that the requested direct physical therapy treatment services may continue, once started, for a period of up to 45 calendar days or 12 visits, whichever occurs first. Thereafter, a physical therapist may continue providing you with physical therapy treatment services only after receiving a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by that physician, surgeon, or podiatrist.

Signature ____

Agreement to Pay for Services Rendered

(Not applicable for authorized Workers Compensation patients)

My signature below verifies that I have read and agree to the above-stated office policies, including an understanding that: Regardless of insurance coverage, I am responsible and liable for payment of all charges assessed for professional services rendered and any fees charged due to my failure to follow the above-mentioned policies. I am responsible for any balance due if my insurance company has not paid within 60 days. In the event that my insurance company remits payment to me for services rendered by PRPT, I will promptly forward payment to PRPT. If it becomes necessary for PRPT to commence legal action for collection of any outstanding charges on my account, I will be responsible for all reasonable fees incurred to collect said charges including collection fees, court costs, and attorney fees.

Signature: ____ Date: __________

Your feedback is important to us; whether it is praise or constructive criticism. Please take a few moments to complete the patient satisfaction survey that will be emailed to you following your visit, and help our practice thrive by recommending PRPT to your friends, family and healthcare providers.