

## **ELEVATE Physical Therapy Policies**

**Co-payments:** Your insurance company may require you to pay a co-payment for physical therapy at the time of service. Many insurers list the co-payment amount on the card beside the OV (office visit). In some cases, physical therapy will fall under the "Specialist" co-payment listed on the card. In other cases, the co-payment may not be on the card at all. We will call to verify benefits but we encourage you to review your policy before you start physical therapy. Co-payments are due at the time of service provided. We do not bill for co-payments. It is the patient's responsibility to stay current with co-payments. We accept cash, checks, credit cards and debit cards.

**Charges:** Responsibility for the full charges of your physical therapy services are yours. It will be necessary for you to make the proper arrangements to handle the uninsured portions of your charges. As a courtesy to you, we will file your primary insurance free of charge on our standard form, provided all necessary information is given. There is a \$20.00 fee on all returned checks. If you are unable to abide by the above policy, please make arrangements with our office staff.

**Cancellations / No Shows:** Being late more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. If you wish to change or cancel an appointment, we require a minimum of 24 hours notice. Anything less will result in a \$10.00 fee charged to your account. Advance notice allows someone else time and opportunity to reserve this appointment. Please be courteous and responsible. There will also be a \$10.00 fee applied for any patient that simply does not show for their appointment.

**Children** requiring supervision are not allowed to attend sessions with you. If your child does not require supervision, and is capable of waiting for you quietly, then you may bring them.

The statements contained herein are true and complete to the best of my knowledge. I understand fully the payment policy and billing procedures of ELEVATE physical therapy. I hereby authorize ELEVATE physical therapy to furnish my insurance company, attorney or legal representative all information which said parties may request concerning my present illness, injury or condition.

I hereby assign to ELEVATE physical therapy, all money to which I am entitled for medical expenses relative to the service reported herein, but not to exceed my indebtedness to ELEVATE physical therapy. It is understood that any money received from the above- named parties over and above my indebtedness, will be refunded (either to me or my insurer, whichever is the source of the over-payment) when my bill is paid in full. I understand I am financially responsible to ELEVATE physical therapy for charges not covered by my insurance company. I certify by my signature that I have read and agree with this information. I also certify that I consent to evaluation and treatment by the staff of ELEVATE physical therapy.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

**\*\*Important Notice regarding cell phones.** We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and either turn OFF your phone or set it to silent mode. Thank you for your cooperation.

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Patient / Responsible Party Name (please print)

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Patient / Responsible Party Signature

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Date