1. As a courtesy to our patients, we will complete any necessary reports and file them with your insurance company to help you collect. *It is in your best interest for you to call your insurance to get your 'Outpatient Physical/Occupational Therapy' benefits, so that you understand and are aware of any limitations or restrictions.*

2. However, I understand that FOCUS PHYSIOTHERAPY does not accept any responsibility for collection of my insurance benefits, or negotiating the settlement of a disputed claim. *I am responsible for all charges, regardless of anticipated insurance coverage*.

3. I understand that my account is considered delinquent if over 90 days old and may be sent to an outside source for collection. I agree to pay collection costs and/or attorney fees associated with collecting my delinquent account.

4. Once the therapist has determined the nature of your problem, treatment plans will be discussed with you. The office staff will advise you of the estimated cost of treatment, at your request. *The patient is responsible for all deductibles, co pays, co-insurance, and other charges not covered by the insurance company at the time of service.*

5. If your health problem is the result of an auto accident, we will bill your primary health insurance company or your personal auto insurance company. We will not, however, be responsible for billing any other party's insurance company; even if they were at fault.

6. Informed Consent- I understand that as a patient of FOCUS PHYSIOTHERAPY…..

- **I have the right to receive complete and current information concerning my diagnosis (to the degree known by FOCUS PHYSIOTHERAPY), treatment and any known prognosis. This information will be communicated to me in terms I can understand by my therapist.**
- **I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, FOCUS PHYSIOTHERAPY has the right to terminate the relationship with me.**
- **I will be informed if FOCUS PHYSIOTHERAPY wishes to participate in or perform any research or educational projects that would affect my care. I understand that I have the right to choose whether I participate, I will receive the most effective care the clinic provides.**
- **Patient's Rights will be posted in a prominent location at all clinics for my review and I can discuss any questions I have with my therapist.**

7. Privacy Policy: I understand there is a copy of FOCUS PHYSIOTHERAPY Privacy Practices posted and it is my right to request a copy of the FOCUS PHYSIOTHERAPY Privacy Policy. I also understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my health information to another entity (my doctor, insurance company, etc.) and I consent to such disclosure for these permitted uses, including via fax. Initial _____

Is there anyone (family, spouse, children, friend) involved in your care or payment related to your care that we can share your health information with?_____

May we contact you by phone for appointment reminders? _ Yes _ No

I have read, understand and agree to all the above.

Patient's Signature _____ Date _____

Assignment of Benefits

I hereby assign all benefits directly to FOCUS PHYSIOTHERAPY and also authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services, I will be financially responsible for payment. Any overpayment will be reimbursed at the end of treatment.

Patient's Signature_____Date_____