

# Towne Physical Therapy Centre

## Authorization/Consent/Financial Policy

### AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Towne Physical Therapy Centre is hereby authorized to disclose all or any part of the medical record of the patient named in the registration to such insurance companies or agencies as may be concerned with the payment of professional and/or facility costs of the patient named on this registration. The authorization is effective for three years from the date of service and may be revoked with written notification

### CONSENT FOR MEDICAL TREATMENT

The undersigned hereby consents to any therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of Towne Physical Therapy Centre as to the results of any treatment given or performed. Please note aqua socks are required for aquatic therapy.

### MEDICARE

Towne Physical Therapy Centre accepts Medicare assignment. This means that we will accept the Medicare approved amount as payment in full for our services. We will bill Medicare and your supplemental insurance company as a courtesy to you. Medicare will pay 80% directly to us and the other 20% must be collected from the patient or from supplemental insurance company. The Health Care Financing Administration (HCFA) of the United States Government has issued a warning that providers who waive the co-insurance charge or the annual deductible for Medicare are subject to prosecution for fraud. We, therefore, must collect the deductible and the remaining 20%. If your supplemental insurance company does not pay or if your Medicare deductible has not been met, you will receive a statement from us indicating the amount you owe. Dressings and supplies will not be covered by Managed Care Organizations or Medicare, therefore, you will be financially responsible for these items at the time of service.

### WORKERS' COMPENSATION

If you are a patient with a valid Workers' Compensation claim, we will bill your employer's insurance carrier for reimbursement on all treatment rendered. If you have reached Maximum Medical improvement as deemed by the insurance carrier, you will be responsible for a co-payment for each visit.

### USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please find and read my financial policy.

### SCHEDULING AND MISSED APPOINTMENTS

It is the patient's responsibility to make and confirm their appointments (date and time). We are unable to guarantee standing appointments but will make every effort to schedule appropriately so that a patient never has an extended wait to see a therapist. If you are unable to attend an appointment, we ask that you call 24 hours in advance to let us know. By calling us, you will allow us to make the appropriate changes to the schedule. **A \$75 cancellation fee will be charged for missed appointments without 24 hour notice.**

### REGARDING INSURANCE

Billing insurance is done as a courtesy to the patient and does not dismiss the patient's responsibility for payment in full. Some companies will pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's ultimate responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. Regarding insurance plans where we are a participating provider all co-pays and deductibles are due prior to treatment. Payments sent to the patient must be forwarded to the provider upon receipt. **By my signature below, I recognize, understand and accept that I am ultimately financially responsible for any and all charges for services rendered by including, but not limited to, any services or fees not covered or denied by my insurance company.** Additionally, I agree to pay all charges associated with the cost of collection, if my account becomes delinquent, including reasonable attorney's fees, court costs, finance charges and the legal rate of interest on the account until paid in full.

### MEDICAL EMERGENCIES

It is our policy to call 911 in case of medical emergencies.

*I certify that I have read and understand fully the above information.*

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date