Phoenix
Physical Therapy

FINANCIAL POLICY AND CONSENT

Patient Name: ______________________________ DOB: ______________

We would like to THANK YOU for choosing Phoenix Physical Therapy (PHX PT). PHX PT accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurances pay a predetermined amount of our treatment charges; however, it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however, we will not take responsibility for any misinformation that we are given during this process. Therefore, it is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm them with our office prior to initiating treatment.

CONSENT FOR CARE AND TREATMENT

I hereby give written consent for the provision of treatment. I authorize PHX PT to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition.

FINANCIAL RESPONSIBILITY

I understand that in some instances the applicable insurance may not cover all treatment charges incurred. I agree to be financially responsible to PHX PT for any medically necessary therapeutic services that are deemed uncovered by my insurance policy. In addition, I authorize PHX PT to release any medical or other information about PHX PT services, or services provided by third parties, if required to obtain payment from my insurer or other payer and their agents to process payments. I also authorize PHX PT to release any medical or other information required by my insurer, other payers and their agents. I also authorize PHX PT to release medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to PHX PT any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by PHX PTfor treatment. By way of my signature below, I provide PHX PT with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES

I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit, according to my insurance benefits and the following PHOENIX Rehabilitation and Health Services policy to reduce the balance billed to me at the end of care: Copays are collected in full. $10 per visit is due **towards** 10% coinsurance, $20 per visit **towards** 20% coinsurance, etc. $50 per visit is due **towards** a deductible.

LITIGATION ACCOUNTS

I understand that PHX PT will directly bill my appropriate insurance; however, I am responsible for the payment of my treatment, not the entity being sued. Liability action against someone else will not enable me to refuse payment to PHX PT. I fully understand that I am directly and fully responsible to PHX PT for all medical bills submitted by PHX PT for services rendered to me regardless of whether my claims are settled or result from a court judgement.

Phoenix
Physical Therapy

FINANCIAL POLICY AND CONSENT

Patient Name: ______________________________ DOB: ______________

PATIENT VALUABLES

I relieve PHX PT of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that PHX PT will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

I consent to receive email, text messages, and calls from PHX PT for my protected health care and other services at the email address and phone number(s), including my wireless number, that have been provided during the intake process. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that providing an email address and/or phone number is not a condition of receiving treatment. I am aware that e-mail communication can be intercepted in transmission or misdirected. I also understand that I may revoke my consent for contact at any time by directly contacting PHX PT or utilizing the opt-out method that will be identified in the applicable communication.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)____
I am entitled under State Law to consent to medical or other health services for myself, and if applicable, for my minor children without the consent of any other person: _________ Patient Initials (required if completing this section)

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

FOR PHOENIX PHYSICAL THERAPY OFFICE USE ONLY

Verification of the identity of the above-named party was made by:

☐ Current Driver's License or other Photo ID

☐ Current Health Insurance Card

☐ Other:

I ACKNOWLEDGE THAT I READ AND UNDERSTAND ALL COMPONENTS OF THE PHOENIX PHYSICAL THERAPY POLICIES AS STATED ABOVE.

______________________________________ ______________
Signature of Patient or Guardian (if patient is a minor **Date**

______________________________________ ______________
Signature of Phoenix Physical Therapy Representative **Date**