RENEW PHYSICAL THERAPY
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CONSENT AND PAYMENT

Consent for Treatment

I consent to treatment procedures and patient care which, in the judgment of my therapist may be considered necessary or advisable while a patient at Renew Physical Therapy.

Renew Physical Therapy may need to contact your health care provider for additional information regarding your diagnosis or treatment. I understand that I have the right to request restrictions on uses and disclosures of protected health information for treatment, payment and health care operations purposes. If such information is withheld by me, I understand that physical therapy treatment may need to be withheld.

I understand that information about physical therapy diagnosis and treatment will be sent to the referring health care provider. This information can be sent to any of my other health care providers should my physical therapist and I deem it necessary and useful.

Insurance Policy

I understand billing my insurance is a courtesy provided to me from Renew Physical Therapy at no additional cost and does not relieve my financial responsibility. I agree that Renew Physical Therapy may furnish the responsible insurance company, and others authorized parties, with necessary information to process physical therapy claims on my behalf in a timely manner.

Co-payments are due at check-in prior to seeing the therapist. If you schedule more than one visit in a week, you may pay in advance for the entire week's co-pays. If you are responsible for a quoted percentage or you have a deductible that has not been met, you will be informed of this. Payment can be made by either debit card, check, HSA or FSA card.

I understand my insurance may have specific limits or restrictions for physical therapy/rehabilitation services and it is my responsibility to be aware and to monitor these limits. I understand I am responsible for all deductibles, co-pays and services not covered by my insurance carrier. If I choose to continue past these limitations, I do understand that I will be responsible for all such visits and balances that go beyond my policies limitations, unless otherwise approved by Renew Physical Therapy and my insurance company. I understand that I am responsible for any unpaid balance. I also understand a 1% (12%APR) finance charge may be assessed to my account if a balance remains unpaid after 60 days.

Most insurance companies have a contracted rate of reimbursement for physical therapy plus a co-payment or patient payment responsibility. Each insurance or third-party payer is different, and benefits vary. We will attempt to contact your company prior to providing services, so that you have an estimate of your benefit coverage. This estimate is not a guarantee of your benefit coverage.

Private Pay / No Insurance

Full payment is due at the time of service. A discount will be applied for payment in full on the day of the appointment.

I have read the above, understand, and agree to its terms.

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Patient/Guarantor Signature ***Date***

You will be provided with a copy of this form for your records upon request.