PRO PT

Professional Physical Therapy and Associates Ltd. Co.

1316 S Ridgewood Ave (U.S. 1), Suite 1• Edgewater, FL 32132 • Tel: (386) 423-0100 • Fax: (386) 428-8631 • www.Proptfl.com

PAYMENT POLICY & CONSENT TO TREAT

PAYMENT POLICY: Our staff will verify your insurance as a courtesy and will notify you the information they receive. Insurances always state it is not a guarantee of payment. As the patient, it is your responsibility to be familiar with your particular insurance policy and its obligations. This includes your obligations to see a participating provider, know your coverage and its limitations, and be prepared to pay any out-of-pocket expenses at the time of your visit. Please refer to our website www.proptfl.com for further explanation.

Health care regulations require us to collect all copayments, coinsurances, deductibles and balances for non-covered service fees. Failure on our part to collect from the patient their financial responsibility can be construed as fraud.

If for some reason you find it necessary to cancel a visit, please call us within 24 hours of your appointment to reschedule, as there is a time on the schedule reserved specifically for you. Cancellations are sometimes unavoidable, however, in order to enforce this policy you will be charged $40 if you cancel less than 24 hours prior or you do not show up to your scheduled appointment. We are obligated to report all no-show and cancellations to your doctor and the involved insurance companies. Worker's compensation patients must take extra precautions in attending physical therapy as treatment can be disrupted for non-compliance.

ACKNOWLEDGEMENT

I have read the above, and understand my responsibilities regarding my insurance coverage and payment policy. I understand that I am responsible for any charges that are not covered by my insurance carrier. I understand that I am responsible to notify the office of any changes in insurance that may occur. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

SIGNATURE: _____ DATE: _____

CONSENT TO TREAT:

I, _____, hereby agree and give my consent to receive medical treatment for my physical condition. I authorize release of any medical information needed to process my claim. I authorize release of payment to **PROFESSIONAL PHYSICAL THERAPY AND ASSOCIATES LTD CO**, regardless of participation in or out of network. I acknowledge that I have received, read and understand the **NOTICE OF PRIVACY PRACTICES.**

SIGNATURE: _____ DATE: _____