The Physical Therapy Place

Financial Agreement

(Please initial each line)

____I understand that I am responsible for all fees resulting from me or my family member's treatment by The Physical Therapy Place, LLC. I understand that I have the primary duty and obligation to pay these fees, notwithstanding any insurance I may have or the existence of any third party payer. I am responsible for furnishing all insurance information and/or workman's compensation details correctly to the Physical Therapy Place prior to treatment, unless other arrangements have been made in advance.

____I hereby authorize my insurance company to pay and hereby assign directly to The Physical Therapy Place all benefits from my insurance company paid as a result of services rendered to me by the Physical Therapy Place.

____I understand that an *outstanding balance is due upon receiving a statement from our billing agency*.

____I understand that I will be billed $80 for any missed appointments, not cancelled within 24 hours prior to the appointment time. Extenuating circumstances will be taken into consideration.

____I understand that accounts unpaid after 120 days may be turned over to a collection agency. In the event that my account is referred to collection, I agree to be responsible for all costs of collecting monies owed, including interest, court costs, collection agency fees and attorneys' fees.

I have read and fully understand the Patient Financial Agreement as outlined above and that I will be given a copy of the Agreement upon request. I understand that this Agreement shall apply to all services provided to me, my dependents, or any other person for whom I have assumed responsibility.

_____

➢ Patient Printed Name Patient signature Date

Privacy Agreement

We are required by law to protect the privacy of your medical information and to provide you with a detailed written notice describing how this clinic may use or disclose medical information about you and how you can obtain or correct this information. Here is a brief summary. Please review carefully.

- The law permits us to disclose information to those involved in your treatment.
- We may disclose your information for billing purposes, gaining insurance or benefits information, insurance authorization and payment for services.
- Your healthcare information may be used during normal healthcare operations.
- We may use your information to contact you, to call to remind you of your appointments, for scheduling purposes, or to inform you of insurance benefits. This may involve leaving messages on an answering machine or with the person who answers the phone.
- We may release some or all of your information when required by law.

Your authorization is required to disclose your health information to other healthcare providers, individuals, or third parties requesting information about you. We will provide a detailed NOTICE OF PRIVACY PRACTICES to you which fully explains your right and our obligation under the law. We may revise our NOTICE from time to time. If you have not yet reviewed a copy of our current notice, a copy will be made available upon request.

Acknowledgement I have received a copy of *The Physical Therapy Place, LLC* Notice of Privacy Practices. I authorize ***The Physical Therapy Place, LLC*** to release any medical information required by my insurance company or worker compensation carrier for the processing of any medical claims filed on my behalf.

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➢ Patient Printed Name Patient signature Date