MAJERUS & CO. PHYSICAL THERAPY

PATIENT TREATMENT & FINANCIAL AGREEMENT

16219 SE 12th Street, Suite 100 | Vancouver, WA 98683 | P: 360.253.4020 | F: 360.604.9293
www.majeruspt.com

We are committed to providing you with the best possible medical and patient support care. Your understanding of our Policies is important to our professional relationship.

MEDICAL TREATMENT

I hereby consent to the examinations, treatments, and recommendations for care as may be directed or approved by the practitioners participating in my health care (including attending physician, his/her colleagues, designees and consultants). I have and will continue to discuss with the practitioner the possible benefits, risks, and alternatives to care authorized by this consent. I understand that no guarantees or promises have been made concerning results of any of the procedures, treatment, examination or care authorized by this consent.

AUTHORIZATION FOR RELEASE OF INFORMATION

The institution rendering services is hereby authorized to furnish and release, in accordance with facility policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third-party agents or agencies from the medical records compiled during treatment. The facility rendering treatment is hereby released from all legal liability that may arise from the release of said information. I also authorize the release of any and all medical records *from other facilities* requested by the above entity, as may be required for completion of the therapist's chart review, assessments, and evaluations. After 90 days, a new signed Release of Information is required.

FINANCIAL RESPONSIBILITY

We participate in most major health insurance plans. As a courtesy to our patients, we will submit insurance claims to your carrier and verify your plan benefits. We expect you to:

- Be responsible for understanding the details of your insurance coverage, including requirements for pre-authorization, annual deductible, co-pay or co-insurance amounts, and visit or dollar limitations for physical therapy services.
- Provide us with a current copy of your insurance card(s) and notify us of any changes in your insurance coverage. If we do not have current insurance billing information, we will expect full payment at the time of service.

Our Business Office team will verify coverage with your insurance carrier; this is however, no guarantee of benefit. Some plans have a set co-pay per visit; some require you pay a co-insurance percentage, after satisfying your plan-year medical deductible. We expect you to:

- Be responsible for any charges not paid by your insurance company within 60 days of our filing.
- If your plan has a co-pay per visit, payment is due at time of service, per our contract with your insurance.
- If your plan has a medical deductible which has not yet been satisfied, a minimum deposit of $100 is due at the time of service.
- If your plan has a co-insurance per visit, an estimated amount will be determined, and payment is encouraged at time of service which applies as a credit to your account. This prevents you receiving a large billing once the insurance has completed processing several claims. We mail patient statements each month after insurance has processed any claims.
- For services not covered by your carrier, such as a medical supply or durable medical equipment (DME) item, an Advanced Beneficiary Notice (ABN) or other waiver for non-covered services may be required to acknowledge your understanding of your responsibility of services not covered. If the service or item is a non-covered service/item, payment is required at time of service.

MEDICARE PHYSICAL THERAPY BENEFITS

Medicare Part B covers physical therapy (PT) up to an annual dollar limit. The amount is determined each calendar year by Medicare; this is a combined benefit with speech language pathology (SLP) services. I will advise this office of any prior PT/SLP visits for this calendar year, as this will impact the Medicare benefits still available to me.

NO SHOW/CANCELLATION POLICY

We are committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. We need **at least 24-hour** notification of cancellation of a scheduled appointment (by phone or in person as email is not reliable). To cancel a Monday appointment, please call our office by 3:00 pm on Friday. When a patient fails to cancel his/her appointment for any reason, within the required time, the following will apply:

- 1st occurrence — No charge, cancellation fee waived
- 2nd occurrence — $25.00 charge
- Each additional occurrence — $50.00 charge ____ initial

If a patient fails to appear for more than two scheduled appointments without prior cancellation, he or she may be dismissed from the practice for failure to comply with the physical therapist's treatment plan.

Payment Plans

If you anticipate that you will need a payment plan, we offer a payment option through CareCredit upon approval, which is a *No Interest If Paid Within Promo Period* covering 6 months. All CareCredit plans feature no up-front costs, annual fees or repayment penalties. For details or to apply, speak with our Office Manager.

Post Treatment Telephone Contact

I authorize that this clinic may contact me by telephone after my physical therapy discharge and signify this consent by initialing here. If not initialed, post treatment contact is not authorized. ____ initial
(*This is especially pertinent if you are here due to swelling or edema, as there can be follow-up treatment or supplies that may be warranted at a later date.)

ASSIGNMENT OF BENEFITS

I authorize payment of insurance benefits directly to Majerus & Co. Physical Therapy. I understand that I am responsible for payment of my account at the time therapy services are rendered. I understand that any insurance I may have is an arrangement between myself and the insurance company and does not relieve me of the liability of payment to this facility. These amounts may include co-payments, deductible, co-insurance, or services not covered. I agree to make a minimum payment of no less than $50.00 per month towards my balance. If a check is returned for insufficient funds, I agree to pay a $25.00 fee. If my patient balance is outstanding for more than two billing cycles (60 days) after applicable insurance monies have been received, I agree that an interest fee of 1.5% per month will be added to my account balance.
In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.
If questions arise, please contact our billing department at 360.263.2950 for assistance. We consider financial matters important and ask you to bring any concerns to our attention.

I certify that I have read, fully understand, and consent to the terms set forth in this document.

Patient Name (please print): _____

Patient/Parent/Guardian Signature: _____ Date: _____