PENINSULA SPORTS MEDICINE

Statement of Office Policies

We appreciate your commitment to:

_____ Being an active participant in your physical therapy treatment by arriving on time for appointments, informing your clinician of any concerns or questions you may have, and complying with home exercise instructions or other recommendations.

_____ Notifying us by phone or email at least **24** hours in advance if you must cancel or change an appointment. A $75 fee will result when 24 hour advance notification is not given. This fee is not billable to insurance. This fee does not apply to workers compensation patients, however the adjuster and referring doctor will be informed of any missed appointments which may result in the denial of additional visits. For all patients, two or more missed appointments without notification will result in a discharge due to noncompliance

_____ Paying co-payments, where applicable, at the time of service. Patients without insurance are asked to pay in full at the time of each appointment. We accept VISA, MasterCard, Discover, checks and cash. There will be a $20 fee imposed for all returned checks.

_____ Knowing the provisions and limitations of your insurance coverage, and understanding that your policy is a contract between you and your insurance carrier.

_____ Providing us with accurate insurance information and the cause of your condition(s) at the start of each episode of care, immediately upon changing insurance carriers, and/or when a new injury occurs.

_____ Paying PSMRC directly for any supplies ordered on your behalf. Should you wish to seek reimbursement from your insurance carrier we can provide you with an itemized statement. Please note that supplies are not covered by many insurance plans.

_____ Understanding that balances over 90 days past due will incur a 1.5% monthly charge (18% APR) and accounts over 120 days past due may be referred to a collection agency.

Authorization and Assignment

I hereby authorize PSMRC to release information necessary to my insurance company in order to process claims for charges incurred by me, and I release PSMRC of any consequences thereof. In consideration of the services rendered to me by PSMRC, I authorize and direct my insurance carrier to remit payment directly to PSMRC.

Signature: _____ Date: _____

Agreement to Pay for Services Rendered

My signature below verifies that I have read and agree to the above-stated office policies, including an understanding that: Regardless of insurance coverage, I am responsible and liable for payment of all charges assessed for professional services rendered and any fees charged due to my failure to follow the above-mentioned policies. In the event that my insurance company remits payment to me for services rendered by PSMRC, I will promptly forward payment to PSMRC.

Signature: _____ Date: _____