BENEFITS: It is a courtesy for Action Physical Therapy to obtain your insurance benefits and to bill for you if we are a Preferred Provider with your plan; however, it is your responsibility to ensure that your benefits are current and active. If we are not a provider with your plan or if you do not have insurance, we can arrange a payment schedule to assist you in the payment of your bill.

CO-PAYMENTS: If your insurance plan has a co-payment, it is required that you pay it at each visit. If your plan has a co-insurance that is due, we will expect that percentage to be paid at each visit and will be based on an estimate of services rendered. If there is a balance owing to you after you have made your co-payment or co-insurance amount, we will bill you for the balance.

MEDICARE: We are a Medicare Part B provider and will accept assignments of benefits. You will be responsible for the portion that Medicare does not cover. As a courtesy, we will bill your secondary insurance once Medicare has paid.

CANCELLATIONS: 24 hour notice is requested when cancelling your appointment. Also, failure to arrive on time for your appointment may result in a modification of your therapy. Failure to make your scheduled appointment without 24 hour notice may be subject to a cancellation fee of $25.00. It is expected that Work Comp patients arrive on time to each visit. A failure to do so may result in a discharge from Action Physical Therapy and may affect your Work Comp benefits.

DISCHARGES: Our office has the right to discharge any patient at any time for non-compliance with their treatment program. Any patient that has not scheduled an appointment within two weeks of the last appointment may be discharged from physical therapy unless previous arrangements have been made with the therapist.

CHART REVIEW: Your chart may be peer reviewed by a medical licensing agency or legal authority to verify that we are complying with the laws and regulations governed by the PT Board of California.

Your understanding of these policies will help us to provide prompt and efficient services for you and all of our patients. If you have any questions or concerns, please speak to one of our staff members, as we are here to assist you.

I UNDERSTAND AND CONSENT TO THE TREATMENT THAT WILL BE RENDERED TO ME AT ACTION PHYSICAL THERAPY WHICH HAS BEEN PRESCRIPED BY MY PHYSICIAN.

SIGNATURE:_____ **DATE**:_____