Restorative Physical Therapy

900 Stanhope Gardens, Suite 101 * Chesapeake, VA 23320
757.842.6562 * 757.842.6563 fax * www.RPTwellness.com

AUTHORIZATION FOR TREATMENT

I hereby authorize evaluation and treatment by Restorative Physical Therapy on behalf of myself and/or my minor children, including stepchildren.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical and/or changes information as is necessary for third party reimbursement from any insurance payer or government agency involved in the payment of my treatment.

OBLIGATION OF PAYMENT

I direct and assign payment from my insurance company to Restorative Physical Therapy I understand that I am ultimately responsible for payment of the entire bill for medical goods or services provided to my children or me and that my insurance policy is a contract between my insurance company and me. I shall pay any deductible and/or co-payment at the time of service. This amount is an estimate of the portion of the fee that is not covered by insurance.

I will advise Restorative Physical Therapy immediately of any changes in insurance coverage or my address.

If I am choosing to seek physical therapy from Restorative Physical Therapy as an out-of-network provider, I will be given the option to pay $75 flat fee, cash/credit/check payment. (Please see front desk staff regarding possible cash pay discounts.)

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

If payment from my insurance company is not received within 90 days, my account will be due and payable in full by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. If a self pay client (i.e. RPT does not take my insurance or my insurance benefits for P.T. are capped out for the year), I will pay amount in full at time of appointment.

If prompt payment is not made, I understand that Restorative Physical Therapy may immediately take action to collect its charges and any outstanding balance. I agree to pay all costs and expenses incurred by Restorative Physical Therapy for collecting any amounts I owe, including court costs and thirty-three and one third percent attorney fees of any outstanding balance. Additionally, I understand that a fee of $25.00 will be applied to my account for any returned checks.

CANCELLATION/NO SHOW CHARGES

Restorative Physical Therapy reserves the right to assess a $25.00 service fee for cancellations with less than 24 hours notification and to all no shows to our office.

ACKNOWLEDGEMENTS

I, the Patient/Guardian, acknowledge that I was given an opportunity to ask questions about the information provided in this form. My signature is acknowledgment of my understanding of and agreement with the provision of this agreement.

Patient/Guarantor signature: _____ Date: _____

Patient/Guarantor print name: _____

Witness signature: _____ Date: _____

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Attendance Policy

Dear valued patient:

Please be aware of the following attendance policy created to best serve you and all of our patients. We look forward to providing quality care for you, and to aid in maximizing benefits from therapy, we need your full participation.

1. Please arrive on time for your scheduled appointment. Please call if you will be more than 10 minutes late. If you are more than 15 minutes late for your appointment, we may be required to reschedule.
2. Please call 24 hours in advance if you know you have to cancel an appointment. We understand emergencies do happen, so in these instances please call as soon as possible to cancel your appointment.

   Restorative Physical Therapy reserves the right to assess a $25.00 service fee for cancellations with less than 24 hours notification and to all no shows to our office.

3. We will have to remove you from our schedule after 3 consecutive cancellations or 2 "no-shows." This may require you to return to the doctor before coming back to therapy. Your doctor will be made aware of cancellations and "no-shows."
4. We are generally flexible with our ability to reschedule appointments. Please call us as soon as you know that you have a conflict in your schedule and we will try our best to accommodate your needs.

Thank you for choosing Restorative Physical Therapy. We are excited to work with you and aid in achieving all your goals!

I have read and understand the above policy:

Signature:_____ Date: _____

Acknowledgement of receipt of Notice of Privacy Practices

Please sign and print your name and date on this acknowledgement form.

Signature: _____

Printed Name: _____

Date: _____

By default, no other persons may have access to my medical records except the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- O I authorize RPT to contact me, and leave messages, regarding my Physical Therapy care and/or appointments on the following numbers:
  Home: _____ Cell: _____ Work: _____
- O I do not authorize RPT to leave any messages regarding my Physical Therapy care.