



## **Honor Physical Therapy Physical Solutions Financial/Consent and Privacy Policy**

I consent and authorize Honor Physical Therapy Solutions to administer all treatments and services that may be considered advisable in her judgment or by the judgment of the client's physician. I understand that the physical therapist may perform testing during the initial visit which may increase my symptoms, as this is a normal physiological response I understand that certain risks and possible injury may occur when participating in a physical therapy program and I hold harmless and release Honor Physical Therapy Solutions of any responsibility for any injury, damages or loss of property that may occur during the use of exercise equipment and/or rehab treatments. I agree that if I am not knowledgeable in the proper use of any equipment that I will obtain instruction as well as not use defective equipment and notify staff of such problems. I will abide to the rules and regulations set forth by Honor Physical therapy Solutions and assume all foregoing risks.

I understand that I am personally being billed for any services or supplies that I may receive at, Honor Physical therapy Solutions and I am agreeing to personally pay out-of-pocket and electing not to have my insurance billed. I agree to be fully responsible for any and all charges accrued related to the delivery of physical therapy treatments. I also understand that I may not go back and choose to have a previous session switched from Self Pay to Insurance billed charges. I understand that I am free to submit any invoices I receive, independently.

**Minors:** The adult/parent accompanying the patient is responsible for full payment of services as described above. Non-accompanied minors coming in for treatment must have prior approval from their parents in order to be treated. Payment must accompany the patient or if agreed upon via electronic bill pay. **Minors of divorced parents:** The parent accompanying the patient or requesting the treatment is responsible for full payment of services as described above, regardless of the divorce decree or settlement.

**Payment:** Full payment is due at the time of service of each visit. If you anticipate difficulty in paying, please discuss a payment plan with Honor Murphy. Any and all outstanding balances over 60 days with no payment plan set-up will be handed over to a Collection Agency.

**Privacy Policy:** Honor Physical therapy Solutions maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our clinic uses patient information to ensure quality care and appropriate billing for services. You may correct, amend, and/or

request a copy of our medical record and history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law. If you have grievance or inquiry pertaining to the privacy of medical records please contact our office.

**Missed appointments:** In order to provide the best possible service to our patients, we require that notification be given at least **24 hours** in advance to cancel any scheduled PT appointment. Because we commonly have a waiting list, please let us know as soon as possible if you need to cancel or reschedule your appointment. You will be charged **\$70** for missing a PT appointment without proper notice. Please make every effort to reschedule your appointment in the same week to avoid a cancellation fee. This fee will be directly billed to you and payment is expected at the next scheduled visit.

PLEASE CHECK ALL THAT APPLIES BELOW:

☐ I AGREE THAT FOR 85 \$ I WILL RECEIVE A FULL PHYSICAL THERAPY EVALUATION.

☐ I AGREE THAT FOR \$80 I WILL RECEIVE AN HOUR PHYSICAL THERAPY SESSION

☐ I AGREE THAT FOR 42\$ I WILL RECEIVE A HALF HOUR PHYSICAL THERAPY SESSION

☐ I AGREE THAT ALL FEES MUST BE PAID AT THE TIME SERVICES ARE RENDERED, UNLESS OTHERWISE DISCUSSED WITH HONOR MURPHY, PT.

**I have read and understand the above policy and I agree to the terms of this policy.**

**\* Signature of Patient or responsible party**\_\_\_\_\_

**Date:** \_\_\_\_\_

**I give permission for my minor child to be treated by Honor Physical Therapy Solutions, without my presence. I agree to be present at my child's Initial Evaluation to discuss plan of care and review any questions or concerns.**

**PATIENTS NAME**\_\_\_\_\_

**SIGNATURE OF RESPONSIBLE PARTY**\_\_\_\_\_

**DATE**\_\_\_\_\_