POTENTIAL
THERAPY SERVICES

Patient Agreement

Consent to Care and Treatment

I, the undersigned do hereby agree and give my consent for Potential Therapy Services to furnish medical care and treatment to _____, which is considered necessary treating his/her physical condition.
(Patient's Name)

Benefit of Assignment

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Potential Therapy Services. A photocopy of this assignment is to be considered as valid as the original._____(initial)

Protected Health Information

I hereby authorize Potential Therapy Services to disclose and/or discuss any/all Protected Health Information associated with my care to the following individuals:

_____Relationship to patient_____

_____Relationship to patient_____

Attendance, Cancellation and No-Show Policy

I understand attendance is expected and necessary to achieve the stated goals of therapy. Should I need to cancel, I will do so 24 hours prior to my scheduled appointment to avoid a no-show charge. _____(initial)

Notification of Video Camera Surveillance

I understand that the gym, office and treatment area of Potential Therapy Services is under video camera surveillance.____(initial)

Financial Policy Statement

As a courtesy to the patient, Potential Therapy Services will attempt to verify your physical therapy coverage with your insurance company. We cannot guarantee the accuracy of the information provided by your insurance company, nor do we guarantee your coverage. You are responsible for the entire balance of your bill. Potential Therapy Services shall bill your insurance carrier solely as a courtesy to you. Potential Therapy Services requires arrangements for payment of your estimated share be made at the time of your initial appointment. If your carrier does not remit payment within 60 days, the balance will be due in full. After 60 days, any balance unpaid shall begin to accrue monthly interest at 1.5%. In the event that your insurance company requests a refund of any payment for any reason, you will be responsible for the amount of money refunded to your insurance company.

The above does not apply to those patients that are covered under Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and such claim is subsequently denied at any time in the future, you may be held responsible for the total amount of charges accrued during your treatment. In the event such Worker's Compensation is denied, and provided that Potential Therapy Services is a participating provider with your insurance plan, we shall, as a courtesy, bill your entire balance to your insurance. Any residual unpaid balances will be your responsibility.

If any payment is made directly to you for any services rendered by Potential Therapy Services, you recognize an obligation to promptly remit the amount to Potential Therapy Services. I authorize the direct payment to Potential Therapy Services of any sum I now or hereafter owe, by my attorney, out of the proceeds of any settlement of my case. I understand and agree that if I fail to make any of the payments of the balance due for which I am responsible, all costs of collecting money owed, including the 1.5% interest monthly on any balances over 60 days, court costs, collection fees and legal fees shall be my responsibility. The collection fee is 25% of the total balance turned over to an outside agency.

Private Insurance and Medicare Patients: I understand and agree that any supply that is not covered or paid for by my insurance company may be my responsibility. I authorize Potential Therapy Services to file appeals with my insurance company or initiate a complaint to the insurance commissioner for any reason on my behalf. I authorize Potential Therapy Services to charge my credit card on file for any unpaid balance due to be sent to collections. I understand that my information will be saved securely on file in my patient account. I have read and understand the above information. I understand my responsibility for the payment of my account.

Patient/Guardian/Responsible Party_____Date_____

Potential Therapy Services Representative_____Date_____