NOTICE OF PRIVACY POLICIES: (copy of our Notice of Privacy Policies attached)

- I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

___________________________________ Date ____/____/_______

Signature of Patient or Guardian:

ASSIGNMENT OF BENEFITS AND CONSENT TO TREAT:

I hereby assign medical benefit to which I am entitled to Lacey Physical Therapy Center, Inc in the event they file on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as responsible costs associated with the collection of this debt. I understand the principal amount owing must be paid immediately of incurring the said debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

- I authorize release of information requested by my insurance plan for payment.
- I understand that I am responsible for any balance due.
- I agree to comply with the terms and conditions as outlined in the Patient Registration form.
- I do hereby consent to such treatment by the authorized personnel of LPTC, Inc. as may be dictated by prudent medical practice by my illness, injury or condition and will cover all subsequent visits to LPTC, Inc. for the length of 12 months from the date of this signature.

___________________________________ Date ____/____/_______

Signature of Patient or Guardian:

CLINIC FINANCIAL POLICIES

INSURANCE COVERAGE: As a courtesy to our patients, we file your insurance claims for you. Bring your insurance card(s) to your initial appointment. Lacey Physical Therapy Center will complete an online verification of eligibility for Physical Therapy services. Every effort is made to obtain correct and complete information. Unfortunately, online information available is not always correct. **It is your responsibility to contact your insurance carrier to obtain a full understanding of your physical therapy coverage.**

CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES: Co-payments are a set amount determined by your insurance carrier and **is due at each therapy visit.** Co-insurance and deductible payments will be billed to you after we have received an Explanation of Benefits from your insurance carrier. Co-insurance and any remaining deductible payments are due upon receipt.

WORKERS COMPENSATION / AUTOMOTIVE ACCICENT: If you are covered for physical therapy services through worker's compensation or Automotive Insurance, we require your claim number, the name and contact numbers of your case manager, and a billing address.

APPOINTMENTS AND CANCELLATIONS: A 24-hour notice is required to cancel your appointment. Lacey Physical Therapy is committed in providing only one to one care. We reserve the right to assess a $40 cancellation fee **(after the first cancellation)** with less than 24-hour notice. This fee is not reimbursable through insurance. We reserve the right to discharge a patient after (3) cancellations with less than 24-hour notice. We also reserve the right to reschedule a patient who is 15 minutes late. Text message reminders of your scheduled appointment times are available if desired. Note: Text message reminders are sent within 24-hours of your appointment.

RETURNED CHECKS: A $35.00 service fee is assessed for returned checks.

OUTSTANDING PATIENT BALANCE: Lacey Physical Therapy Center is here to help our clients. If you have an outstanding account, please contact our office to make payment arrangements. We will work with you to ensure the arrangement works for both parties. If your account is over 60 days without any payment arrangement in place, then Lacey Physical Therapy Center will automatically move the account to small claims.

Assistance with understanding your insurance coverage is available through our Patient Accounts Manager at 668-5930. We look forward to our partnership in your recovery.

The undersigned accepts all responsibilities for treatment costs not covered by third party payers.

___________________________________ Date ____/____/_______

Signature of Patient or Guardian:

Revised 11/18/19