FINANCIAL POLICY

• INSURANCE- Your insurance policy is a contract between you and your insurance company. It is your responsibility to be aware of your insurance coverage, limitations, and terms and conditions. Verification of benefits are performed as a courtesy to you. Summit Physical Therapy AZ are not responsible for information that is obtained from your insurance carrier that is later deemed inaccurate. You are contractually responsible for your co-payment, co-insurance or any balance unpaid at the time of service. We accept Cash, Check, Visa, MasterCard, and Discovery.

• NO INSURANCE- Patients who are self-pay are responsible for the entire balance at the time of service. In certain cases alternative payment options may be considered.

• REGARDING INSURANCE- We will bill your insurance company upon receipt of your current insurance information. If your insurance company has not paid your account in full within 45 days, the balance may automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and are not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Non-covered services will be billed to the patient.

• MEDICARE MEDICAL NECESSITY- Medicare will pay only for services that it determines to be "reasonable and necessary" under the Medicare laws. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment, you are personally and fully responsible for payment.

• NO-SHOW/LATE CANCELLATION- If you must cancel your appointment, you will be required to cancel 24 hours before your appointment time. "No-show" patients and cancellations with less than 24 hour notice will be charged a $25 fee. IF THIS OCCURS 3 OR MORE TIMES YOU MAY BE TERMINATED FROM THE PRACTICE

• RETURNED CHECKS- There is a $25.00 fee if you check is returned unpaid. In addition, any future services will require cash or credit card payments.

• STATEMENTS- Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date.

• COLLECTIONS- Should it be necessary to place your unpaid account with our outside collection agency, you must communicate directly with them.

I have read, understand, and agree to abide by the financial policy of Summit Physical Therapy AZ.

X_____ _____

Patient or Responsible Party Signature Date

Medicare Patients Only:

Have you had any therapy services elsewhere this year? (Circle one) Yes No

If you answered Yes, have you been discharged? Yes No

Home Health:

Is anyone coming to your home to provide services at this time? Yes No

Acknowledgement of Receipt of Privacy Practices

SUMMIT PHYSICAL THERAPY AZ

I, _____ am aware of Summit Physical Therapy AZ's notice of privacy practices policies which went into effect on April 14th, 2003. I understand that I may request and receive a copy of these policies.

Signature of Patient _____ Date _____

PATIENT INFORMATION CONSENT: I have read and fully understand Summit Physical Therapy AZ's Notice of Privacy Practices. I understand that Summit Physical Therapy AZ may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations by notifying the practice. I also understand that Summit Physical Therapy AZ will consider requests for restriction on a case by case basis, but do not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Summit Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature of Patient _____ Date _____

MEDICATION LIST including vitamins or supplements

Patient Name:

DOB:

Medication	Dosage	Frequency	Route of Administration

Drug Allergies:

Consent for Treatment

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Summit Physical Therapy AZ and hereby authorize and give my consent for Summit Physical Therapy AZ to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Patient Signature: _____ Date:_____

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize and give my consent for Summit Physical Therapy AZ to treat (minor's name) _____while I am not present.

Patient/ Guardian/ Responsible Party Signature	**Date:**