Loudoun Physical Therapy
Expert care for life-changing results.

Today's Date: ____________________

Registration Agreement

Please initial each item.

_______ **Medical Consent** – I, the undersigned, consent to treatment and procedures, which may be performed during the physical therapy sessions, with Loudoun Physical Therapy, Inc. personnel under the general and special instructions of my physician or surgeon. I have the right to know the identity of those providing patient care, including students. I have the right to refuse any treatment and to be informed of the possible medical consequences of refusal. My signature on this document indicates my general consent to be treated. My therapist and/or members of the Loudoun Physical Therapy, Inc. may request that I sign a more specific form relative to any procedure which may be performed.

_______ **Release of Information** – Loudoun Physical Therapy, Inc. and/or the therapists providing the services in the Loudoun Physical Therapy facility may disclose any or all parts of my medical records to my insurance carrier(s) and any organization(s) contractually responsible for purposes of satisfying all charges billed by Loudoun Physical Therapy. In addition, I authorize Loudoun Physical Therapy, Inc. to disclose any or all parts of my medical records to any organization(s) for the purpose of arranging continuing care deemed necessary. I further understand that it may be necessary for Loudoun Physical Therapy, Inc., the therapists, and/or the business staff to contact my/our past or present employer(s) in regard to any insurance claim.

_______ **Referral and Pre-certification Requirements** – I hereby take full responsibility for all referrals and pre-certification requirements as described or requested by my insurance company. I understand it is my duty and responsibility to contact the insurance company to make certain that the referrals have been issued. I further understand that failure to provide a referral or pre-certification information to Loudoun Physical Therapy, Inc. could result in reduced coverage and that I will take full responsibility for payment of all balances due.

_______ **Financial Responsibility** – I, the undersigned, agree and personally guarantee in consideration of services and materials provided by Loudoun Physical Therapy, Inc. or the therapists to be responsible for payment in full of all Loudoun Physical Therapy, Inc. bills and/or therapist's bills. In the event that any unpaid accounts are turned over to an attorney or collection agency for collection, I shall pay 100% of the attorney's fees; interest on the unpaid principal balance at the rate of 18% per annum; and all other legal fees and collection agency's cost pertaining to this encounter. Payment of my portion of the bill (co-payments, percentage, and deductible) is due at the time of each visit. If I choose not to have claims filed by Loudoun Physical Therapy, Inc., full payment is due at the time of each treatment rendered.

_______ **Cancellation/No Show Policy** – If I am unable to keep my appointment, I understand that I will need to call by 12:00PM the business day prior to my given appointment time to avoid any cancellation fees (excluding holidays). Late cancellations, no shows, and late arrivals after 20 minutes will be charged a fee of $50.00; my missed appointment could be someone else's appointment. If I cancel late or no show 3 times within the course of my treatment, I understand I would be automatically discharged and will not be accepted back to Loudoun Physical Therapy, Inc..

_______ **Personal Valuables** – I hereby release Loudoun Physical Therapy, Inc. from any responsibility for valuables, money, personal or other possessions which are brought in at the time of treatment. Loudoun Physical Therapy, Inc. assumes no responsibility for the safety of dentures or eyeglasses as these must be available for patient's daily use.

_______ **Therapists** – I, the undersigned, recognize that all therapists furnish services to the patient bill under the group name of Loudoun Physical Therapy, Inc.

_______ **Other Conditions** – I, the undersigned, further state that the foregoing Registration Agreement has been carefully read, and I understand the contents there of, and have signed as my own free and voluntary act, and have not been influenced in executing this Registration Agreement by any representative of Loudoun Physical Therapy, Inc. or its agents. I hereby acknowledge the continuing nature of this agreement unless or until withdrawn in writing by me.

_______ **Assignment of Benefits** – I, the undersigned, hereby authorize Loudoun Physical Therapy, Inc. to apply for benefits on my behalf for the services rendered by Loudoun Physical Therapy, Inc. and request that the payments are made directly to Loudoun Physical Therapy, Inc.. I certify that the information I have reported about my insurance coverage is correct. I also authorize the group to release all necessary information including medical information for this and any related claim, in order to determine benefits to which I am entitled. I permit a copy of this authorization to be used in place of the original.

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Patient, Parent, or Guardian Signature | Date Signed | Admin Initial