FINANCIAL AGREEMENT — ASSIGNMENT OF BENEFITS
CONSENT TO TREAT — PRIVACY PRACTICE ACKNOWLEDGEMENT

Thank you for choosing ARC Physical Therapy + for your rehabilitation. We are committed to providing quality medical care. Our office has adopted the following Financial Policy. We require that each Client/Patient read and agree to this Financial Policy prior to beginning treatment. If the Client/Patient is a minor, we require a co-signature of a Parent or Guardian at each opportunity.

Insurance

Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. We will file claims to your insurance company. All health plans are not the same and they do not always cover the same services. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including your deductible, coinsurance and co-payment amounts. It is your responsibility to notify our office when either your insurance plan or benefits change.

Deductibles/Co-payments/Payments

Our insurance contracts require us to collect deductibles, coinsurance and copays. Co-pay amounts will be collected at each visit prior to service being rendered. For your convenience we accept Visa, MasterCard, Discover and American Express in addition to personal checks and cash. If your check is returned to us for insufficient funds, we will assess a service charge of $30 for each occurrence. When you provide a check as payment, you authorize us to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction "And" When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

Financial Agreement

☐ Self Pay/Health Insurance: If I have no insurance, I understand that payment will be made at the time the services are rendered unless financial arrangements have been made PRIOR to the services. A statement will be mailed to me each month showing the total balance due from me and will be considered past due within 30 days from receipt. Items billed to my insurance will become past due it no reply is received within 45 days. If I am unable to make payment in full, I understand that I should call the billing department immediately @ 913-831-2721 to make payment arrangements. I understand that if no payment has been received after 45 days, my account may be referred for collections. If my account is referred for collections, I understand that I will be responsible for the balance as well as all collection costs and reasonable attorney's fees.

☐ If my therapy is a work related injury and has been approved by my employer or employer's representative as a work injury, I understand that my employer or work comp carrier will be financially responsible for payment of my treatment.

_____ _____

Signature of Client/Patient **Date**

_____

Printed Name of Client/Patient

Consent for Treatment

While I am here, I permit the clinicians to treat me in ways they judge are beneficial to me. I understand that the clinician will explain to me the nature of my condition and their recommended treatment.

_____ _____

Signature of Client/Patient **Date**

Assignment of Benefits

I hereby authorize ARC Physical Therapy + to release all information necessary to secure payment. I assign all benefits for unpaid services to which I am entitled to ARC Physical Therapy +. This assignment will remain in effect until revoked by me in writing.

_____ _____

Signature of Client/Patient **Date**

Privacy Practice Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I understand that if my care is due to a work related injury; my records will be released to the case manager, worker's compensation insurance carrier, employer at the time of injury and referring doctor. If this is not work related, my records will only be released to my own insurance company and the referring doctor. Any other persons you wish for us to release information to must be requested by you in writing on an approved form.

Additional comments/restrictions on the use and disclosure of my protected health information:

You must choose one of the following:

☐ I give consent to release and/or leave a message regarding appointments, treatment or other information as necessary on answering machine at home, voicemail on cell phone or at work, or with _____ Relationship:_____.

☐ I do not consent to messages containing protected information being left.
Please contact me directly at ( ) _____ - _____ or ( ) _____ - _____.

Additional Comments/Restrictions: _____

_____

_____

_____ _____

Signature of Client/Patient **Date**