

Consent Form | Financial Agreement | Privacy Practices | Cancellation Policy

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 use information from your check to make a one-time electronic fund transfer from your account.

Financial Agreement

- Self Pay: I understand that payment will be made at the time the services are rendered.
- Private Health Insurance/Medicare: We collect on copays, deductible amounts and co-insurance at the time services are rendered. If there is a remaining balance 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. If I am unable to make a payment, I understand that I should call the billing department immediately at 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.
- Workman’s Compensation: 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 my private health insurance, Medicare or workman’s compensation carrier for reimbursement for services provided. I agree to provide such information as needed to establish my eligibility for such benefits. This statement 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.
- I give consent to speak with the following person/s regarding my treatment:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
- I do not consent to messages containing protected information being left.
Please contact me directly at () _____ - _____ or () _____ - _____.

Signature of Client/Patient

Date

Signature of ARC Witness

Date

Cancellation/No-Show Policy

It is our policy at ARC Physical Therapy+, that in the event of a cancellation or no-show, regardless of the circumstances, the following will occur:

- **Your case manager, adjustor and physician will be notified via phone and/or fax (for Workers Compensation Only)**
- **Your appointment will be rescheduled later on that day or on the next business day**
- **If you are greater than 15 minutes late, it will be the treating therapist’s discretion whether or not you will be treated or rescheduled.**

I have read and understand the policy stated above. I will attend my scheduled appointment times and in the instance that a cancellation is necessary, will call in advance to notify my treating clinician.

Signature of Client/Patient

Date