Patient Consent and Financial Agreement

*_____ I hereby authorize treatment by *ANEW Physical Therapy*. I understand that I am financially responsible for all charges incurred for services rendered regardless of litigation, insurance reimbursement, or pending Labor & Industry Claims. I understand that the parent accompanying a minor for any treatment will be responsible for payment. I authorize the release of any necessary information requested by my insurance company and/or attorney. I authorize payment directly to *ANEW Physical Therapy and Wellness.*

*_____ I understand that ALL co-payments, and /or out of pocket payments, are due on the day of treatment. We have a signed contract with most insurance companies that state we are to collect co-pay on the day of your scheduled appointment. It is the patient responsibility to verify physical therapy coverage and co-payment.

* _____ I am committed to my health and attending my physical therapy appointments. I understand, in the event I need **to cancel** my appointment, I will provide Anew Physical Therapy with a **48 hour** cancellation notice in order to avoid a $45 fee, payable prior to my next visit.

*_____ I understand, in the event I do not show up for my appointment all future appointments maybe cancelled until I call for new appointments.

Out of Network Patients: As a courtesy, we will bill your insurance company for you if we are given a copy of your insurance card and all pertinent information to do so. Your insurance is a contract between you, your employer and your insurance company. The insurance will pay you. We are not a party to that contract, therefore, it is the responsibility of the patient to determine if there is coverage for the services being rendered, obtain prior authorization if necessary. Patient is responsible for payment at time of service.

If you are involved with a third party litigation, arrangements will need to be made with the billing manager before any further appointments.

* _____ All patient balances older than 60 days are subject to a 5 % per month interest/billing charge. Please note that balances over 90 days may be sent to a collection agency.

*Please initial and sign that you have read and you agree with the above***.**

Patient or Parent Signature_____ Date _____

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