Haile Physical Therapy, LLC
410-571-1151

Consent Form

Financial Agreement: I understand that I am responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay copayment and coinsurance as services are rendered. I understand my insurance is a contract between myself and my insurance company and Haile Physical Therapy (HPT) will be my insurance as a courtesy to me. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/ or preauthorization is required by my insurance company, I will assist HPT in obtaining the referral and / or preauthorization. If payment cannot be made at each visit I will notify my therapist and make other arrangements. I understand that I am ultimately responsible for any balance on my account. I certify that the information provided to HPT is accurate and up-to-date. Current insurance information must be on file at each visit for claims to be submitted appropriately. If new insurance information is provided after services are rendered I may be responsible for the account balance. If all attempts to collect reasonable amounts due fail and this account has been referred to a collection agency for action I agree to pay all costs associated with the process allowed by law.

Assignment of Benefits: I hereby assign HPT such benefits to which are entitled under my insurance plan(s).
Release of Information: I hereby allow HPT to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney or other providers of service as necessary to obtain payment for services and provide additional care.
Consent for Treatment: I hereby allow HPT to examine and treat that the therapist deems necessary once discussion of said treatment occurs.

Privacy Practices: HPT is required by law to maintain the privacy of a patients' protected heath information. In addition, we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. I have read and agree to the above. My signature below indicates that I have also received a copy of the HPT Notice of Privacy Practices and I have indicated any restrictions of my protected health information. Scanned signatures suffice as originals.

No Show and Late Cancellation Policy: I understand that HPT will charge me $75 (not my insurance company) for a No Show, a forgotten appointment or not giving at least 24 hours notice for a cancellation. This charge is to cover the hour long time slot that has been reserved for my personal care.

The undersigned certifies that I have read the forgoing and I am the patient or the parent or guardian of the patient or the duly authorized patient agent to execute the above and accept its terms.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Patient/ Responsible Party Name Relationship to patient