

Policies & Procedures Agreement

Parmenter Physical Therapy
1582 W. San Marcos Blvd., Suite 105, San Marcos, CA 92078
Phone: 760.203.8474 Fax: 760.780.1589

Financial Arrangements

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and me. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if my insurance is suspended or terminated while I am undergoing treatment I am responsible for payment for services rendered.

Insurance Billing /Payment

Our office will make an effort to verify insurance benefits as well as bill your insurance company. Patients are however, fully responsible for services provided by our office. Please note that verification of benefits does not ensure payment and your insurance company makes the final decision on payments of claims. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients are also responsible to update Parmenter Physical Therapy with any changes in insurance coverage. Failure to do so may result in non-payment by the insurance company, the balance is the responsibility of the patient for payment.

Payment Arrangements

Payment is due within 30 days of the service rendered. If there is a legitimate financial problem, please discuss that with our office prior to the 30 days so we may reach a workable solution.

Deductibles/Copays

PPO's – We no longer bill PPO insurances. However, a superbill can be sent to you upon request. A superbill can be submitted to your insurance company for potential reimbursement of visits. Check with your insurance company prior to submitting.
Medicare – Medicare pays for reasonable and necessary services. Services given to Medicare patients must be within 30 days of the date of the Dr.'s referral.

Cash Payment

For those of you that do not have insurance, find that your insurance is not contracted for physical therapy services at our location, or decide to pay cash instead of insurance, we offer a cash prices. Should you choose this option, you will need to sign the Cash Payment Consent Form.

Informed Consent for Physical Therapy Treatment

I request and consent to the performance of physical therapy services for myself or the person listed below for whom I am responsible. These services include evaluation, assessment, and treatment which may include manual therapy, modalities and exercise programs which are permitted under physical therapy state licensure. I understand that the results of treatment are not guaranteed. I further understand and am informed that there are potential risks to physical therapy treatment as in all practices of medicine. Although rare, risks may include but are not limited to worsening of symptoms, fracture, stroke, strains and sprains. I do not expect the physical therapist to be able to predict all risks and complications but wish to rely on their ability to exercise professional judgment during the course of my care to make decisions, based on facts that are known, in my best interest.

Record Release Authorization

I authorize Betty Parmenter Physical Therapy to release and furnish any information related to the care of my present illness or injury to my Insurance Company and other medical physicians or practitioners whose care I am under. I authorize payment of medical benefits to Betty Parmenter Physical Therapy for services provided to me.

HIPAA: I was presented with and offered a copy of the HIPA
A notice of privacy practices.

CANCELATION POLICY: Cancellations must be done 24 hours in advance of a scheduled visit for you not to be penalized. You will have a grace period of 2 visits before a **cancellation fee of \$50.00** is added to your billing. Actual emergencies and medical reasons upon our discretion can be excused from this policy.

Name (please print)

Signature

Date