



results PHYSIOTHERAPY PAYMENT FOR SERVICES RENDERED

As a courtesy to our patients we will perform the initial insurance verification, complete any necessary reports and file them with your insurance company to help with the collection process. Because of the variability among insurance group policies, **it is your responsibility and not that of Results Physiotherapy to understand your 'Outpatient Physical Therapy' benefit with your insurance plan.**

Below is the information we received from your insurance company concerning your benefits:

Primary Insurance

Deductible: _____

Deductible Balance: _____

Out of Pocket: _____

Out of Pocket Balance: _____

Copay/Coinsurance: _____

Secondary Insurance

Deductible: _____

Deductible Balance: _____

Out of Pocket: _____

Out of Pocket Balance: _____

Copay/Coinsurance: _____

If your insurance company has informed us that your deductible has not been met but you feel that this is inaccurate, due to recent medical attention or procedure, then we will only collect your copay/coinsurance. Should your insurance company roll your cost to your deductible when we file your claim you will be billed for the outstanding balance amount.

THIS IS NOT A GUARANTEE OF BENEFITS. I understand that Results Physiotherapy files my insurances as a courtesy but does not accept any responsibility for any misinformation that we have received. I am responsible for negotiating the settlement of any disputed claims and for all charges, regardless of anticipated insurance coverage.

I understand that my account is considered delinquent if over 90 days old and may be sent to an outside source for collection. I agree to pay collection costs and/or attorney fees associated with collecting my delinquent account.

Patient's Signature _____ Date _____



results PHYSIOTHERAPY PRIVACY AND ASSIGNMENT OF BENEFITS

Auto Accident: If your health problem is the result of an auto accident, you must provide us with your auto insurance information and major medical policy information. We will file with your Auto Carrier if you have an open med pay account/claim otherwise we file with your medical insurance. We do not file with Third Party payors unless arranged prospectively. For Medicare beneficiaries with an open Auto/ No Fault, liability, or worker’s comp claim we must submit claims to the respective Third Party.

Informed Consent: I understand that as a patient of RESULTS PHYSIOTHERAPY:

- I have the right to receive complete and current information concerning my diagnosis (to the degree known by RESULTS PHYSIOTHERAPY), treatment and any known prognosis. This information will be communicated to me in terms I can understand by my therapist.
- I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, RESULTS PHYSIOTHERAPY has the right to terminate the relationship with me.
- I will be informed if RESULTS PHYSIOTHERAPY wishes to participate in or perform any research or educational projects that would affect my care. I understand that I have the right to choose whether I participate. I will receive the most effective care the clinic provides.
- Patient's Rights will be posted in a prominent location at all clinics for my review and I can discuss any questions I have with my therapist.

Privacy Policy: I understand there is a copy of RESULTS PHYSIOTHERAPY Privacy Practices posted and it is my right to request a copy of the RESULTS PHYSIOTHERAPY Privacy Policy. I also understand that as part of this organization's treatment, payment, or health care operations it may become necessary to disclose my health information to another entity (my doctor, insurance company, etc.) and I consent to such disclosure for these permitted uses, including via fax.

Is there anyone (family, spouse, children, and friend) involved in your care or payment related to your care that we can share your health information with? **Yes No**

If yes, Contact Person Name: _____

May we contact you by phone for appointment reminders? **Yes No**

May we email you with updates newsletters, etc. to keep you informed and updated with the latest information in health/physical therapy? If so please give us your email address:

Email Address: _____

How did you hear about us? Please circle one:

- | | | |
|-----------------------------------|------------------------------|----------------|
| 1. Physician | 5. Friend or Family Member | 9. Advertising |
| 2. I am a past patient | 6. Co-worker | 10. Other |
| 3. Work Related Injury | 7. Sports team, school, club | _____ |
| 4. Internet/Website/Search Engine | 8. Insurance Company | _____ |

Assignment of Benefits: I hereby assign all benefits directly to RESULTS PHYSIOTHERAPY and also authorize release of any medical records necessary to process medical claims. **I understand fully that in the event my insurance company or financially responsible party does not pay for the services, I will be financially responsible for payment.** Any overpayment will be reimbursed after all claims have been processed and paid through insurances.

Patient’s Signature _____ Date _____