FINANCIAL AGREEMENT

Thank you for choosing ***Focus Physical Therapy*** as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Agreement that we require you to read carefully and sign prior to any treatment. A copy will be provided to you upon request.

Insurance. We participate in most regional insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. All patients are encouraged to call their insurance company for verification or clarification of benefits. **Knowing your insurance benefits is your responsibility.** In most cases, ***Focus Physical Therapy*** will bill your insurance, however, any account balance incurred with ***Focus Physical Therapy*** is legally your responsibility. The adult, parent or legal guardian accompanying a minor is responsible financially for all services provided by ***Focus Physical Therapy*** and agrees to all terms listed herein.

TERMS OF AGREEMENT

I, the undersigned, hereby agree with the following:

1. **Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on Focus Physical Therapy's part to collect co-payments and deductibles from patients can be considered fraud. I will help Focus Physical Therapy in upholding the law by paying my co-payment at each visit.**
2. **Non-covered Services/Equipment.** I am aware that some - and perhaps all - of the services/equipment I receive may be non-covered, denied by my carrier or not considered reasonable or necessary by Medicare or other insurers. I understand that I am financially responsible for all charges not paid by my insurance company.
3. **Proof of insurance.** I will provide a copy of a current, valid, insurance card to provide proof of insurance. I will notify a Focus Physical Therapy representative of any changes in my information, including, but not limited to, address, phone number, or insurance coverage.
4. **Claims submission.** My insurance company may need me to supply certain information directly. It is my responsibility to comply with their request. **I am aware that Insurance coverage does not guarantee payment.**
5. **Missed appointments.** I understand I will be charged $30 for missed appointments not canceled within 24 hours of the scheduled time. These charges will be **my** responsibility and not covered by my insurance.
6. **Assignment of Benefits.** I, the undersigned, certify that I (or my dependent) have insurance coverage as provided to ***Focus Physical Therapy*** and assign directly to ***Focus Physical Therapy*** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X____

Signature of Patient or Responsible Party: **Date:**

Burke M. Selbst MPT, CMDT, GCFP Owner | Alison J. Cobb MPT

901 NW Carlon Ave, Bend OR 97701 PH 541.385.3344 FAX 541.312.5256
EMAIL INFO@FOCUSPHYSIO.COM
WEB www.focusphysio.com

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Consent for the Use and Disclosure of Protected Health Information

By signing below, you consent to the use and disclosure of your protected health information by ***Focus Physical Therapy***, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of use and disclosures for these purposes, please review our Notice of Information Practices. You have the right to review our Notice of Information Practices prior to signing this consent form. The terms of this Notice of Information Practices may change. If this occurs, a revised notice will be posted in our facility. You may also obtain a revised copy by contacting ***Focus Physical Therapy*** at (541) 385- 3344 and requesting one.

You have the right to request that we restrict our use or disclosure of your protected health information otherwise permitted for Focus Physical Therapy to use in treatment, payment and health care operations. We are not required to agree to these restrictions, however, if we do so, the agreed restrictions are binding on us. You have the right to revoke this consent in writing, except to the extent that we may already have taken action in reliance on it.

X____

Signature of Patient or Responsible Party: **Date:**

Consent for Care and Treatment

As the patient or patient's legal representative, I hereby consent to any necessary examination, procedures, and/or treatments recommended by my therapist(s) at ***Focus Physical Therapy*** as necessary in his/her judgment and delivered in accordance with all local and national laws pertaining to physical therapy. I understand that I am under the care and supervision of the treating therapist at ***Focus Physical Therapy***. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

- If you are unable to provide information about your medical history, please provide the name(s) of person(s) from whom we may obtain this verbal information:

  Name: _________________________________ Relationship: ________________

X____

Signature of Patient or Responsible Party: **Date:**

Email List

If you would like to subscribe to Focus Physical Therapy's email list to receive occasional educational and clinic related information, please provide your email address here:

Email Address: ____

Your email address will be held strictly confidential, and will never be distributed to any other company or individual, at any time, for any purpose.

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Verify Your Insurance Coverage

Thank you for verifying your own insurance coverage. This process should only take a few minutes of your time, and will help you avoid costly expenses if there are problems or gaps in your insurance coverage.

Things You'll Need:

1. Your Insurance Card
2. Your Social Security Number and Date of Birth
3. Focus Physical Therapy Information such as Tax ID # (included on the bottom)

Call the number on your insurance card, or go to your insurance company's website.
Ask for or go to the section for **checking eligibility and benefits**.
Complete this form and bring it and **your insurance card** to your next PT visit.

PATIENT INFORMATION
Your Name: ________________________________ Date:___________________
Your Date of Birth: _____________ Your Social Security Number: _______________

INSURANCE INFORMATION

Insurance Company Name________________________________
Ins. Company Phone # (from the back of your card)_______________________

ID Number_______________________________________
Group Number___________________________________
Effective Date_____________________________________

is Focus Physical Therapy (circle one): **preferred** **participating** **out of network?** *Is Pre-Certification/Prior Authorization Required? Yes No*

Annual deductible? ____________
Amount already met? ____________

Co-pay amount ___________% or $

Visit Limit:_____________
Visits used this year:___________________
Yearly/Lifetime Maximum (visit or $ amount):_______________

Insurance Requires the following (circle): Doctor's Referral Evaluation Daily Notes

Focus Physical Therapy, Inc. Tax ID# 20-3140657 Burke M Selbst, PT

Thank you for taking the time to complete this form. We look forward to working with you!

Burke M. Selbst MPT, CMDT, GCFP Owner | Alison J. Cobb MPT

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