Karen Holmes Physical Therapy, LLC

FINANCIAL AGREEMENT

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me, instead of Karen Holmes Physical Therapy, LLC, I will immediately deliver such payment directly to Karen Holmes Physical Therapy, LLC. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. Returned checks and balances 30 days or over may be subject to additional fees.

Please initial______.

I hereby give authorization for payment of insurance benefits to be made directly to Karen Holmes Physical Therapy, LLC for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

____Date___/___/

Signature (Parent or guardian signature if patient is a minor)

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective.

APPOINTMENTS

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of 15 minutes or more may result in a shortened treatment or cancellation. We require advance notice of 24 hours of cancellation. **Failure to show for an appointment or cancellation without sufficient notice will be subject to a $25.00 charge. Insurance will not pay this charge.**

CO-PAYMENT POLICY

Patients that carry health care insurance should remember that some policies require a co-payment for each visit. Consequently it is your responsibility as defined by your policy to make these co-payments.

I understand and agree that I am solely responsible for all co-payments and charges incurred which are not covered under my health care plan. I also authorize the release of any medical information necessary to process this claim.

AUTHORIZATION FOR TREATMENT--INFORMED CONSENT

I hereby consent to and authorize these treatments, which in conjunction with the judgment of the referring physician may be considered necessary or advisable for the diagnosis or treatment of the above named patient. I understand I have the option to refuse any or all of the treatment recommended by the physical therapist. Please initial_________.

____Date___/___/___

Signature (Parent or guardian signature if patient is a minor)

Patient Name (please print)____