Madison Physical Therapy, LLC –
Treatment, Consent, Insurance and Payment Policies

CONSENT FOR CARE AND TREATMENT:

I do hereby consent to physical therapy services at Madison Physical Therapy, LLC. In doing so, I understand there are no guarantees to the result of treatment. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. _____ (Initial Here)

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. Any payments not made on the date of services shall be due and owing within thirty (30) days of the date of invoicing. By signing this document and agreeing to treatment, you agree to pay interest on any amount due and owing thirty (30) days after invoicing at the Category A rate of interest in SDCL 54-3-16.

With in-network insurance coverage: Your calculated **ESTIMATED** patient portion for each visit is $_____. This amount is based on information gathered from your insurance company as a courtesy service to you. Per your insurance, your benefits are listed as following:

Deductible: $_____ Ded - Remaining: $_____

Out of Pocket Maximum: $ _____ OOPM - Remaining: $_____

Copay/Co-insurance: _____ Visit limits: _____

Authorization Required: YES OR NO _____

The amount stated above will be collected from you before each visit. All additional amounts owed as patient responsibility will be billed to you each month in an itemized patient statement.

With out-of-network insurance coverage: Your **AGREED** patient portion is $_____ per visit towards your deductible up to $_____ and then $_____ for each visit after the deductible is met. This is a discounted rate and our courtesy for paying at the time of service for all costs.

No insurance/private pay: Your **AGREED** patient portion is $_____ a visit and this amount will be collected from you at the time of service.

I understand my ESTIMATED Financial Responsibility for services as stated above. _____ (Initial Here)

INSURANCE POLICY/ASSIGNMENT OF BENEFITS:

I request that payment of insurance benefits be made on my behalf to the provider for any services furnished to me. Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and other pertinent information. **You are responsible for all deductibles and charges not covered by insurance**. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations. This is your responsibility. _____ (Initial Here)

CANCELLATION/NO SHOW POLICY:

Our office requires a 24 hour notice for cancelling an appointment. If we do not receive notification of cancellation within 24 prior hours, a $60 cancellation/no show fee will be charged for that visit to the payment method on file by close of business on Friday of the week of the appt. _____ (Initial Here) After 3 No Show/No Call appointments, all future appointments will be removed from the schedule until the patient and/or guardian contacts our office to reschedule.

CREDIT/HSA CARD ON FILE AGREEMENT POLICY:

I, _____, the undersigned, authorize Madison Physical Therapy to charge my credit/debit card for services rendered and charges incurred at the rates agreed upon in the financial policy. This includes service charges relative to billing and missed appointments or cancellations with less than 24 hours notice.

I understand that my information will be saved on file for future transactions on my account. The Provider agrees to make every effort to keep all credit card information confidential and secure and to process payments to my card only after the agreed upon fee has been incurred. The Provider will only utilize this information when I am not physically able to present my card at the time of service.

This authorization will remain in effect until I cancel this authorization. I may cancel this authorization at any time by providing written notification to Madison Physical Therapy, LLC. Authorization will end within 30 days of receipt of said written notification.
_____ (Initial Here)

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ DATE: _____
Patient, Parent or Guardian