life's work®
physical therapy

Treatment Consent
I hereby voluntarily consent to an initial evaluation and all further treatment provided by any Life's Work provider. I understand that I have the right to ask for detailed explanations of all aspects of my treatment. I understand that being a patient at Life's Work is voluntary and my case may be studied as part of a research database.

Release of Information Consent
I understand and consent that health information received or created in the course of the delivery of health care at Life's Work will be used or released for treatment, payment and health care operations as described in the "*Notice of Privacy Practices".* A copy of the "*Notice of Privacy Practices"* is posted in the clinic, and a copy is available at any time upon request.

Responsibility for Personal Property
I agree that Life's Work is not responsible for my personal items

Statement of Financial Policy
At Life's Work Physical Therapy, we understand that the various payment systems for healthcare services can be confusing. The following information is provided to help you understand our financial policies. As a patient at Life's Work, you will hear financial terms like co-payments, co-pays, co-insurance, deductibles and balance due. If you ever have a question about the cost of services or what you may owe, please let us know.

General Policies
Patients are responsible for prompt payment of their co-pays, deductibles and any balances due on bills. Co-pays are due at the time of service. If there ever comes a time when you would need to make payment arrangements, please contact us. We are happy to set payment arrangements for your balance due. A $20.00 rebilling fees will be accrued monthly for balances over 30 days past due. * see payment options handout for details.

Insurance
We ask that you provide current and accurate insurance information at each visit. Keep in mind that your insurance policy is a contract between you and your insurance company. As part of Life's Work Physical Therapy, we will file your insurance claim directly to your insurance plan. However, primary responsibility for the account is yours. If your insurance plan does not pay the practice within a reasonable period or we do not have current insurance information on file, we will look to you for payment. Not all insurance plans cover all services. In the event your insurance plan determines a service is 'not covered' you will be responsible for the complete charge.

- Medicare – We accept assignment for Medicare. If you have supplemental and/or secondary insurance, please provide that information and we will bill for you
- Workers' Compensation – We will need the name of your insurance carrier, the date of injury, your employer and claim number, if available.
- Motor Vehicle Accident - We will need the name of your insurance carrier, the date of accident and claim number, if available.

Other Terms

- Checks returned for insufficient funds will be subject to a $25.00 service fee
- Your prompt payment will be appreciated. If you maintain any unpaid balances exceeding 120 days and you have not made payment arrangements with us, we reserve the right to turn your account over to an outside collection agency. If we do so, we will charge a processing fee of $100.00. If it is necessary to assign your account to an outside collection agency and/or attorney, you will be responsible for attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal.

Cancellation Policy
Patients who provide less than 24 hours notice of cancellation may be charged directly $35.00 for the first late cancellation.
Future late cancellations or no-shows require full payment for the visit or $125.00. These fees will not be billed to your insurance; it is your responsibility and will need to be paid in full before your next visit. Patients who frequently fail to notify us of cancellation within 24 BUSINESS hours may be removed from the schedule at the discretion of the staff.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name Relationship to Patient