CONSENT AND FINANCIAL POLICY

Thank you for choosing New Life as your physical therapy provider. We are privileged to serve you and are committed to providing the best care possible. Please review the information below:

1. **CONSENT TO TREAT** I consent to treatment and authorize my physical therapist and others who aide in my care to provide care and treatment. Specific treatment plan and interventions will be explained to me by my physical therapist along with benefits and potential risks or side effects. **Signature is required to provide treatment.**

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(required if patient is under 18 years old)

2. **ATTENDANCE AND CANCELLATION POLICY** I understand that part of my ability to achieve my goals and a successful outcome in physical therapy is my consistent attendance at appointments. I also understand that New Life and my clinician may have a wait list of other patients on any given day needing appointments. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and that cancelling less than 24 hours prior to an appointment or not showing for an appointment may result in a $50.00 cancel/no show fee. If I have consistent attendance issues, I understand that my future appointments may be cancelled and I may be asked to call in for same-day appointments when I for sure know my schedule and can commit to attending. I also am aware that if I show up more than 10 minutes after my scheduled appointment time that I may be asked to reschedule
3. **PAYMENT RESPONSIBILITY** I acknowledge that I am financially responsible for my treatment and bill at New Life. It is my responsibility to provide New Life with my current insurance information and familiarize myself with my insurance plan and benefit coverage. I am responsible for updating New Life on any insurance coverage or policy changes throughout my care. I understand that I am responsible for any uncovered services due to an insurance change of which I fail to inform New Life. I understand that New Life will submit claims to my insurance carrier and I am responsible for any allowed patient responsibility after insurance payment and contractual adjustments. I am aware that not all services provided may be covered by my insurance, and any uncovered charges will be my responsibility. New Life will work with you to help determine the extent of benefit coverage; however does not guarantee that my insurance company will pay for services rendered.
4. **SECURING YOUR ACCOUNT** I understand that I am required to pay my co-payment at time of service. Due to the variability of coinsurance and timing of deductibles, these are not required to be paid at time of service, however for your convenience and credit protection we offer one of the following options:
   a.) I may wait to receive a bill after claims processing and for my credit protection may secure my account with a credit or flex card. I understand that once I receive my statement I will have 30 days to pay my balance or contact New Life's billing department to arrange a payment plan. In the event I do not pay or contact New Life, I understand my credit card on file will be charged my statement balance.
   b.) I may choose an upfront payment plan where I will pay an agreed upon amount toward my estimated out of pocket costs to avoid an unaffordable large statement balance at end of service.
   c.) I may wait to receive a bill after claims processing and choose not to secure my account with a credit or flex card. I understand that overdue statements may be referred to Cascade Credit collections.
5. **PAST DUE ACCOUNTS** 1 1/2% interest will be added monthly to account balances over 30 days. If your account becomes overdue, it may be referred to a collection agency and/or attorney. Legal fees that we pay to secure past balances will be added to your account. In the event your account is submitted to an outside collection agency, you give your permission to release the necessary information, personal or otherwise, to

the outside agency and you acknowledge that you are aware that this information may become a matter of public record.

6. **RETURNED CHECKS** A $25.00 fee will be charged for each check returned to us unpaid by your bank.
7. **ACCESS AND RELEASE OF HEALTH INFORMATION** I authorize New Life to bill my insurance on my behalf. I authorize my therapist and those involved in my care to contact other healthcare professionals that may have related information to my health care as deemed appropriate by my therapist. I have received New Life's Notice of Privacy HIPAA Policy and understand how my health information may be used and disclosed and how I can gain access to my health information at New Life.
8. **COMMUNICATION WITH MY CARE TEAM** I authorize the following means of communication with those involved in my care:

   Voicemail: Administrative staff and my clinicians may leave me detailed voicemails _____ (initials)

   Email: New Life may communicate with me regarding my care via the email address I provided. Understand that New Life's email system is secure and all access is password protected, however does not fall under encryption guidelines of most recent HIPAA updates. _____ (initials)

9. **PATIENT CONTACT INFORMATION**

   Name: _____

   Mailing Address: _____

   Phone #: _____ **Secondary Phone #:** _____

   Email Address: _____

10. **HIPAA INDIVIDUAL AUTHORIZATION** I authorize the following individuals to receive verbal information regarding the billing of my account or my care at New Life:

_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship

11. **CONSENT FOR EMERGENCY CONTACT**

In the event of an emergency, please contact:

_____	_____	_____
Name	Telephone Number	Relationship

Please note that refusal to sign this form does not change responsibility for payment in any way.

By signing below, I certify that I have read, understand, and fully agree to each of the statements in this document and have had the opportunity to discuss any questions that I have regarding information presented.

_____	_____
Signature of Patient or Legally Responsible Person	Date

_____
Printed Name

If you have any billing or financial concerns, please contact your Patient Services Team Member