BE Fit
PHYSICAL THERAPY

Patient Name: _____

Please initial each line:

___ I consent to physical therapy services at BE Fit Physical Therapy. If I have any questions about my care, I should ask my physical therapist about them. It is up to me to inform the physical therapist/staff about any health concerns, allergies or questions I have regarding my care. I understand I need to keep my physical therapist informed about and drugs or medications I am taking, and alert them as any medication changes occur.

___ I agree to pay for services provided by BE Fit Physical Therapy. The fees for services are based on reasonable and customary charges for this area. BE Fit will bill the insurance provided. It is my responsibility to update insurance records when necessary. BE Fit offers competitively priced self pay options. If I do not have insurance or choose not to use my insurance BE Fit will ask that all balances are paid at the time of service. Not paying at the time of service may subject me to a higher rate.

___ I will be responsible for charges not covered by my insurance company including, but not limited to deductibles, co-pays, non authorized, beyond timely filing and/or denials for non-medically necessary charges. I am also responsible for payment of any cancellation charges, supplies and additional cost incurred in collecting overdue balances.

___ BE Fit's **Cancellation policy is 24 Hours Notice**. By cancelling or rescheduling my appointment with less than 24 hours another patient may lose the ability to schedule in the open time slot and the physical therapist's treatment time is lost. I will respect the schedule of the therapist and the value of the treatment time. I will hold myself accountable for arriving on time to my scheduled appointments. If I arrive 10 minutes or more late for an appointment, my therapist may not have the time to treat me or my total visit time may be reduced. If BE Fit feels that I am not giving them the courtesy of canceling in a timely fashion (24 hrs before my appt) I may be subject to a **$20.00 cancellation or no-show fee**. By signing below I agree to payment of this fee.

___ It is BE Fit's policy to subject any patient balances not paid after 120 days to a 3% interest charge. I will pay all statements upon receipt. If I am having trouble paying my balance then BE Fit can help to break the payments out into smaller increments. If I would like to pay deductibles or projected out of pocket cost in advance I may. In the event that the patient balance is less than expected on an advanced payment I would be guaranteed a refund of any overpaid amount.

_____ _____

Patient/Responsible Party Signature **Date**

My signature below indicates that **I have been offered a copy of BE Fit's HIPAA Notice of Privacy Practices**. This is a policy we must abide by to ensure the confidentiality of your medical records. Your records will only be released to your insurance if they require it. Progress notes will be sent to the physician offices you have provided to us.
If you are over the age of 18 and would like to permit any individual to have access To your medical record or financial record, please list their full names and their relation to you below:

Full Name	**Relation**

_____ _____

Patient/Responsible Party Signature **Date**