mti physical therapy
PROVIDING ONE-TO-ONE CARE

FINANCIAL POLICY

PLEASE READ CAREFULLY AND SIGN

It is your responsibility to know the limitations and restrictions of your insurance company regarding physical therapy. By signing below you hereby authorize your insurance benefits to be paid directly to MTI Physical Therapy. You are responsible for paying your balance regardless of your insurance company's payments. **Copays are due at the time of service.** If your insurance company does not cover physical therapy and you choose to pay out of pocket for treatment, your balance is due at the time of your appointment.

In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and collection fees. If legal action is taken against your account, you agree to pay all reasonable attorney fees, filing fees and any other costs associated with this action. Checks returned without sufficient funds will be charged a $35.00 fee.

_____ _____

Signature of Patient or Legal Guardian *Date*

Missed Appointments & Cancellations: appointments not kept or cancelled without 24 hours notice prior to the scheduled appointment time will be charged a **$95.00** cancellation fee. These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. If you miss 3 appointments without proper notice, all future appointments will be cancelled.

_____ _____

Signature of Patient or Legal Guardian *Date*

WASHINGTON ATHLETIC CLUB MEMBERS: The services provided under this agreement are being provided solely by Manual Therapy International (dba MTI Physical Therapy) and not the Washington Athletic Club (WAC). The provider is an independant contractor. The WAC is not responsible for costs incurred for physical therapy treatment.

PRIVACY POLICIES STATEMENT/HIPAA

You have the opportunity to review and question our privacy policies statement at your request. This statement outlines our policies that protect your privacy. We will release your personal health information for billing purposes to be reimbursed for services rendered or to facilitate your care with another of your health care providers. You may request (in writing) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for your balance and it will be your responsibility to submit claims to your insurance carrier for reimbursement.

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Signature of Patient or Legal Guardian *Date*