

Mountain2City Physical Therapy, PLLC

Consent for Care and Financial Agreement

Initial	Please read the following closely and initial when finished
_____ Initial	<p>Cancellation/No Show Policy: Mountain2City Physical Therapy, PLLC has a 24 hour cancellation/rescheduling policy. If you miss your appointment, cancel, or change your appointment with less than 24 business hours' notice, you will be charged a \$50 fee. If you no-show or late cancel two or more visits your care may be discontinued. These charges cannot be billed to any insurance and are your full responsibility.</p>
_____ Initial	<p>Financial Policy:</p> <ul style="list-style-type: none"> • I understand billing my insurance is a courtesy provided to me from Mountain2City Physical Therapy, PLLC at no additional cost, and does not relieve my financial responsibility. I agree that Mountain2City Physical Therapy, PLLC may furnish the responsible insurance company, and other authorized parties with necessary information to process physical therapy claims on my behalf in a timely manner. • Co-payments are due at the time services are rendered. All other balances will be billed to the insurance carrier presented at your appointment and once processed I understand I am fully responsible for all balances not covered by my insurance, including but not limited to deductibles, copays, and co-insurances. I also understand that my insurance may have specific limits or restrictions for physical therapy/rehabilitation services and it is my responsibility to be aware and to monitor these limits. • I agree to make full payment within 30 days of receiving any and all bills, unless other arrangements are mutually agreed upon.
_____ Initial	<p>HIPAA/Consent for Care:</p> <ul style="list-style-type: none"> • I grant permission for licensed physical therapists at Mountain2City Physical Therapy, PLLC to perform such examinations and therapeutic procedures and exercises as may be professionally necessary or advisable for appropriate evaluation and treatment of my condition. • As permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize the release of any and all medical information to my physician(s) and other healthcare providers as may be necessary for communication regarding my care. Additional person I would like my health information to be made accessible to are noted below. • As permitted by HIPAA, I authorize the release of any and all medical records to my insurance company upon their request. Other release is subject to my written consent. • I have received, read, and understand my privacy rights and practices (HIPAA).c

I have read and understand the above policy.

Signature: _____ Date: _____

I authorize the following persons to have access to my health information:
