

ELDORADO PHYSICAL THERAPY POLICIES AND CONSENTS

Please ***Initial beside each policy and sign at the bottom.***

_____ **CONSENT FOR TREATMENT:** I authorize Eldorado Physical Therapy to furnish necessary treatment/ procedures. I understand that the practice of rehabilitation is not an exact science and acknowledge that no guarantees have been made to me to as to the result of such treatment.

_____ **IT IS MY RESPONSIBILITY:** to provide all insurance coverage information at the time of admittance. Not doing so may result in my receiving a bill directly from Eldorado Physical Therapy. Eldorado Physical Therapy will bill my insurance directly as a courtesy to me.

_____ **CO-PAYS/DEDUCTIBLES:** I understand that if my insurance plan requires any payment from me, that **it is due on the day of service.** If a deductible is due, I agree to pay \$120 for evaluation and \$100/ visit until I meet my deductible. Depending on my plan and the insurance allowable, I understand that additional payment, or a refund, may be due at the end of the billing cycle.

_____ ***LATE POLICY:** I understand that if I am late for my appointment, I will be seen at the provider's discretion. If I am more than 10 minutes late, I may be asked to reschedule and a missed appointment fee of \$50 may incur.

_____ ***MISSED/ CANCELLED APPOINTMENTS:** I understand that EPT has a **24 hour cancellation policy.** If I fail to show up for a scheduled appointment or fail to give 24 hour notice of a cancellation I **may be charged a \$50 fee.** (Monday appointments must be cancelled no later than the Friday before).

_____ **I AUTHORIZE** Eldorado Physical Therapy to bill my insurance company on my behalf and to release any relevant information necessary to provide this service.

_____ **I AUTHORIZE** my Therapist to furnish Telehealth treatment if appropriate and agreed upon during my course of treatment.

Medicare clients only: (please initial)

_____ Lifetime Medicare B signature Authorization: I authorize any holder of medical or other pertinent information about me to release information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of Eldorado Physical Therapy in reference to a Medicare claim. I permit a copy of this signature authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of the authorization on my behalf. I understand that I am financially responsible for any deductibles and coinsurances.

Patient/guardian signature

Date