FYZICAL Therapy & Balance Centers

Policies Agreement

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

If the above criteria are not met, you are welcome to participate in our elective services such fitness/exercise training, payable out-of-pocket by cash, check or credit card.

Cancel/No-show/Late

Unless cancelled 24 hours in advance, our policy is to charge you for the missed appointment at the rate of $15 and a rate of $25 for a "No-show". Please help us serve you better by keeping your appointments.

Authorization for Release of Records
Assignment of Benefits (for insurance patients)

I understand that FYZICAL Therapy & Balance Centers may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating quality of service and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed if I notify the practice. I also understand that FYZICAL Therapy & Balance Centers will consider requests for restriction on a case-by-case basis but does not have to agree to request for restriction. I hereby consent to the use and disclosure of my personal health information for the purposes as noted in FYZICAL Therapy & Balance Centers Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Results

The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients

It is your responsibility to know your benefits and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs (Currently 35% of balance).

Medicare Patients

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents

If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent

By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.

Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Notice of Privacy Practices

I have received a copy of and/or acknowledged the posted Notice of Privacy Practices for FYZICAL Therapy & Balance Centers.

Patient Declaration

The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

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Patient/Guardian Signature Date