FINANCIAL POLICY AND CONSENT FORM

Health and accident policies are an arrangement between you and your insurance company. As a courtesy to you, we will bill your insurance carrier(s) for you, although **you are responsible** for all charges incurred at this facility.

Most insurance policies cover physical therapy, although the amount they pay varies from policy to policy. We, therefore, urge you to carefully review your coverage with your carrier, in addition to the verification sheet you signed today with us.

SPECIAL NOTE TO ALL PATIENTS: 24-hour notice is required if you are canceling your appointment. If you miss an appointment or cancel without sufficient notice you will be charged $25.00 for each cancelled appointment. This charge is **due and payable on or before your next appointment.** If you are covered under worker's compensation, **you, not your insurance,** will be billed for any charges resulting from failed appointments. Additionally, **we will notify your claims adjustor/case manager of any failed visits.** Please note our office has a 24-hour answering machine for your convenience and for weekend scheduling changes.

INITIAL: _____

Interpreting Appointments:
Appointments that are paired with an interpreting service provided by Capitol Physical Therapy, INC, require 72 hours notice to cancel or change your appointment. Our office will only pay for one failed appointment interpreting service fee. If a change or cancellation of appointment that is not made prior to the 72 hours needed incurs a service fee with the interpreting agency, any remaining physical therapy visits scheduled will be cancelled at the discretion of Capitol Physical Therapy.

Patient Consent for Use and Disclosure of Protected Health Information

I hearby give my consent for Capitol Physical Therapy Center (CPTC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (The Notice of Privacy Practices provided by CPTC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. C_PTC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Capitol Physical Therapy Center, 1308 28th Street, Sacramento, CA 95816.

With this consent, CPTC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

Signed:

With this consent, CPTC may mail to my home or other alternative location any items that assist the pratice in carrying out TPO, such as correspondence and patient statements.

With this consent, CPTC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that CPTC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow CPTC to use and and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CPTC may decline to provide treatment to me.

______________________________________ ______________________________
Signature of Patient of Legal Guardian Date

____
Print Patient's Name