Capitol Physical Therapy

Financial Policy and Consent Form

Financial Policy

- Health policies and liens 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
- The specific coverages of your plan are checked for you as a courtesy, however you are responsible for knowledge of the coverage of your insurance policy for physical therapy.
- **I understand that I am financially responsible for my health insurance deductible, co-payments, co-insurance, or non-covered service.** _____ (initial here)
- **I understand that should services be denied by my insurance, I will be responsible for the complete charge and agree to pay the cost of services.** _____ (initial here)

Cancellations

- We ask for at least 24 hours' notice when cancelling an appointment. However, we understand that there are sometimes events outside of your control. Failure to notify Capitol PT when cancelling an appointment may result in a no-show charge at the discretion of Capitol PT. Such a no-show charge would be the responsibility of you the patient, not your insurance.
- **I understand that at least 24 hours' notice is required when cancelling an appointment. Failure to do so can incur a $25.00 charge at the discretion of Capitol PT.** _____ (initial here)
- **I understand that if no notice is given of a cancelled or missed appointment, a $75.00 charge may be incurred at the discretion of Capitol PT.** _____ (initial here)
- **I understand that any such no-show charges will be my responsibility and will not be paid by my health insurance.** _____ (initial here)

Protected Health Information

- Capitol PT agrees to uphold the standards and protections detailed in the Health Information Portability and Accountability Act of 1996 (HIPAA).
- Your protected health information (PHI) will only be used or disclosed when necessary for the performance of treatment, payment, and healthcare operations
    - This can include correspondence by mail, e-mail, or phone at my stated addresses
- **I understand that Capitol PT may use or disclose my PHI only when necessary for treatment, payment, and healthcare operations.** _____ (initial here)

Consent to Treat

- While being treated at Capitol PT, you have the right to be fully informed of the expected Plan of Care, and the right to accept or refuse the initial Plan of Care as well as any changes to the Plan of Care.
- **I understand that, while being treated at Capitol PT, I have the right to accept or refuse the established Plan of Care. I consent to being treated by Capitol PT under the Plan of Care agreed upon by my therapist and myself.** _____ (initial here)

Signature: _____ Date: _____