EXPERIENCE EVERY DAY.

Alpine Physical Therapy & Spine Care

FINANCIAL POLICIES

Thank you for choosing Alpine Physical Therapy (APT) for your rehabilitation needs and we appreciate the confidence you have shown in choosing us to provide you with the best possible care. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your insurance coverage and bill the insurance on your behalf. However, you are ultimately responsible for the payment of your bill. ***Deductible and Co-payments are part of your contractual agreement with your insurance company and it is our responsibility as participating providers to collect those fees.***
Co-payments are due at each visit. You will receive an itemized monthly statement showing any additional charges and the total amount due on your account. Payment in full is required within 30 days, unless arrangements are made with our billing office, Praxis Medical Group, 877-708-1119.

We do not bill Third Party insurances (another person's insurance), so if you are being treated for an injury related to a work or motor vehicle accident, please discuss the specifics of your claim with the front desk so we can ensure proper billing and reimbursement.

MEDICARE: Physical therapy is a covered service through Medicare, for treatment deemed medically necessary, up to $2080 for 2020 (*approximately 18 visits*). Our therapists are participating providers with Medicare, and we will attempt to bill Medicare as well as any supplemental insurance provided. You are financially responsible for any remaining co-insurance or annual deductible as applicable.

> *****PLEASE NOTE:** If you have previously attended physical therapy in this current year with another clinic, or are currently being treated at another location for a separate issue, please notify the front desk so we can make the required notations to your account.*

24 HOUR CANCELLATION POLICY: ***Please provide our office with 24-hour notice to change or cancel an appointment.*** Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 cancellation fee. These charges cannot be billed to your insurance company and will be your responsibility. After two missed or cancelled appointments without the appropriate 24 hour notice, you may be placed on a same day scheduling policy, which would not allow you to schedule any appointments in advance.

Patient (or Guardian) Signature ______________________________ Date ______________

Please refrain from wearing perfumes, colognes and scented lotions for therapy sessions. Due to allergies and enclosed, small spaces, even the mildest scents can become overwhelming to the sensitivities of others.

CONSENT FOR TREATMENT: By signing below I am requesting Alpine Physical Therapy provide evaluation and/or treatment as prescribed by my physician and/or recommended by the therapist. I understand the practice of physical therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that I have the right to ask questions at any time during the course of my care, and that I may refuse treatment or services at any time. I understand Alpine Physical Therapy does not guarantee any outcome for any services or treatment, either stated or implied.

Patient's Name (please print) ______________________________ DOB: ______________

Patient's Signature ______________________________ Date ______________

Parent/Guardian Signature (for minors) ______________________________

PATIENT PRIVACY AND CONFIDENTIALITY

We are dedicated to protecting the privacy and security of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your Protected Health Information (PHI) is never compromised is a principle concept of our practice. During the course of treatment, it may be necessary to share information with other medical providers, but your PHI will never be given to anyone, even family members, without your consent. We follow all Federal and State regulations regarding PHI and information will only be released with the written authorization of the individual in question.

The **Notice of Privacy Practices** describes the uses, disclosures and practices followed by the employees and staff of APT and your rights regarding your health information. You have the right to receive and review a written description of how Alpine Physical Therapy will handle your PHI. This written authorization may be revoked at any time. If requested, we can provide you with a copy of our "Notice of Privacy Practices".

***By signing below you agree that you have reviewed and understand the above information and that you are entitled to have a copy of APT's **Notice of Privacy Practices**. Copies are available at the reception desk.*

The **Health Insurance Portability and Accountability Act (HIPAA)** gives you the right to request that we communicate financial and/or medical information to you in confidence. In order to protect the privacy and confidentiality of your information please complete the following:

I give permission to APT to leave messages regarding:

☐ Appointments ☐ Billing Information ☐ Limited Medical Information, such as: recommendations, treatment plans, referral status or plan of care updates

Please select the number(s) where messages can be left:

☐ Home ________________________ ☐ Mobile ________________________ ☐ Work __________________________

And/or with the following person(s) should I be unavailable:

Name: ___________________________________ Relationship: ______________________ Phone: ___________________

Name: ___________________________________ Relationship: ______________________ Phone: ___________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Praxis Medical Group, DBA Alpine Physical Therapy & Spine Care to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

I authorize my healthcare providers to release personal health information as it pertains to my rehabilitative care if any is requested by Alpine Physical Therapy & Spine Care.

Patient's Name (please print) _______________________________________ DOB: __________________________

Patient's Signature ____ Date __________________________

Parent/Guardian Signature (for minors) ____