Welcome!! We take pride in offering individualized care. You will see that we are a unique facility in several ways. **Thank you for the opportunity** to show you what makes us distinct. Allow me to have your attention for a few moments to share just a few key points which will make your physical therapy experience productive and satisfying.

We are here to provide the greatest quality of care and best customer service possible. We do so by encouraging your active participation. Your input and satisfaction is valuable to all of us. Satisfaction surveys are available in our reception area for you to offer your opinion at any time during your care here in our facility. Please let us know what you think.

Protection of your privacy is valuable to us. Please refer to our privacy practices and your rights posted in our reception room as well as the written notice offered to you today. **By signing this form you have given Lake Country Physical Therapy and Sportscare, PC (also referred to as LCPT) authorization to obtain and/or release any protected health information necessary to your physician(s), attorney(s),insurance company(s) and/or their representatives. LCPT also expects you will respect and protect the privacy of personal health information of fellow patients.**

Our business office representative has assisted you in completing all the necessary paperwork to bill your insurance carrier for services rendered. Every insurance carrier has different policies regarding outpatient physical therapy coverage. We will secure insurance payment by verifying eligibility for physical therapy and assuring prior approval and when applicable authorization for treatment. **By signing this form you are stating you have given LCPT your correct insurance information and your insurance company covers physical therapy at our facility. Your signature also indicates you have given your insurance company (s) authorization to make payments directly to LCPT for services rendered. Your signature is an agreement to pay in full for all treatment, services, fees and supplies that are not covered by your case management agency and insurance company(s).** LCPT will notify you in advance to receiving any potentially uncovered services, treatment or supplies. You will be responsible for letting us know if there are any changes in your coverage. If LCPT does not participate with your insurance company(s), you will be given an estimate on the cost of each session. If you do not have insurance it is $100.00 for an evaluation and $100.00 for treatment.

Effective 11/23/06 you may receive an initial evaluation visit and 10 subsequent visits or 30 days of treatment without a visit or prescription from your physician, dentist, podiatrist, physician assistant or nurse practitioner providing your physical therapist has 3 yrs of full time working experience. After 11 visits you must get a prescription from your physician, dentist, podiatrist, physician assistant or nurse practitioner. If you were initially given a prescription by your physician to attend PT, then you and your physical therapist will discuss the need for continued physical therapy beyond the expiration of the initial physician prescription / referral form. Your physical therapist will ask you for your assistance with obtaining an updated prescription from your referring physician. You and your physical therapist will discuss and agree to the need for any type of service before it is rendered. This does not remove the insurance referral requirements for your health insurance to cover the cost of your services. Most medical offices will require an office visit before calling your insurance carrier for a referral for physical therapy. **Each session your physical therapist will explain your treatment plan. Signing of this form acknowledges that you received an initial evaluation and your physical therapist discussed your condition and plan for treatment. Your signature acknowledges your willingness to receive treatment and your ongoing understanding of the nature, purpose and potential implications of your treatment plan. Your signature implies willingness to participate by keeping your appointments and performing your home program**.

Your physical therapist will complete all documentation and charges for your services at the point of service. Please be sure to sign in and out each visit to us, documenting both the arrival and departure time.

We will do our best at scheduling your appointments at times when it is convenient for you to attend. We reserve this time for you. If you cannot keep an appointment you are responsible for giving us 24 hours notice and for rescheduling your appointment so the goals established your first visit can be met within the time frame established by your therapist and referring physician. **The same day cancellation fee is $50.00 and no show fee is $100.00. You will be responsible for the payment of this fee at your next scheduled appointment. PAYMENT IN FULL IS DUE AT THE TIME YOUR SERVICES ARE RENDERED.** If payment is not made a **$50.00 late fee** will be applied to your account. You will be responsible for the payment of this fee at your next scheduled appointment. If a monthly statement must be mailed to you, then an **additional $50.00 billing fee** will be incurred. At your last session you will be responsible for full payment of your portion of the bill. If for any reason you do not pay your portion at the point of service and we need to send you a monthly statement, LCPT will only send two monthly statements. Each will have a **monthly billing fee of $50.00**. If you fail to make arrangements for payment within 10 days of the last statement, your name will be forwarded to a collection agency or an attorney. You will be liable for any collection agency fees and/or attorney fees associated with the collection of your account. There is a **$50.00 return check fee**. We accept credit or debit cards.

We outsource billing to Clinicient, Inc. Billing insurance carriers is done daily. In the event an agency or insurance carrier does not cover a provided service, you will be notified by mail of your responsibilities for payment. Do not be surprised if you do not hear from us right away. We will attempt payment from your insurance carrier until we are certain the company will not cover the services rendered. We will not knowingly provide services which are not covered by your insurance carrier. We are committed to staying on top of each insurance carrier's billing policies. **Should you get a statement for a balance due and have questions, then please call the 800# listed on your statement.**
Please keep us informed of any changes in your policy.

We hope you will enjoy your stay here with us at Lake Country Physical Therapy and Sportscare, PC. Please let us know what we can do to help make your experience a gratifying one.

_____ I hereby acknowledge that I have read & received a copy of the practice's **HIPAA Notice of Privacy Practices/ Advice**.
_____ I hereby have **refused a copy** of this medical practice's **HIPAA Notice of Privacy Practices/Advice**.
If not signed by the patient, indicate. Relationship: Parent or guardian of minor patient
Guardian or conservator of an incompetent patient

Name of Patient: ______________________________ Date of 1st Visit ________ Account # ________
Address: ____

Patient financial responsibilities include any services rendered not covered by your case management agency or insurance carrier, supplies, all applicable service fees and your copayment of ___________ or
____
____
____
____
____.

If you do not have insurance or your insurance does not cover services rendered, the first session self-pay is $200.00 and each subsequent session is $100.00.

I HAVE READ, UNDERSTAND and AGREE WITH THE CONTENTS OF THIS FORM.

For Office Use Only:
Patient received privacy notice Y/N
Patient provided copy of this form Y/N
Patient refused a copy of this form Y/N
Business Office representative initials ________

_by checking this box please accept my esignature____________________
PATIENT OR AUTHORIZED PERSON SIGNATURE

Date __________________

PT Signature___________________________ Zoe Fackelman, PT Date _____________