

Welcome to Canyon Physical Therapy & Aquatic Rehabilitation!

It is our goal to provide "Uncompromising Care" designed to alleviate your pain and maximize your physical abilities. We will teach you ways to manage your current symptoms and care for yourself in order to prevent injuries in the future. Today you will see a licensed Physical Therapist who will evaluate your injury/condition and tailor a treatment program to meet your individual needs. Together we will set short and long terms goals in an effort to facilitate your rapid recovery. During your rehabilitation process, it is extremely important that you keep all of your appointments and follow the instructions given by your therapist. We look forward to working with you and are committed to your well-being.

FINANCIAL AGREEMENT

I understand and agree that I am solely responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a courtesy only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me, instead of Canyon Physical Therapy & Aquatic Rehabilitation, I will immediately deliver such payment directly to Canyon Physical Therapy & Aquatic Rehabilitation. I understand and agree that all bills are considered past due after 30 days and payment is required at such time. Past due accounts will be assessed a 1.5% interest charge per month. Please contact our office if payment arrangements need to be discussed. Should it become necessary to start collection proceedings for any unpaid account balance, you will be responsible for these collection charges and they will be added to your account. It is agreed that if payment is delayed because Canyon Physical Therapy & Aquatic Rehabilitation has agreed to accept a lien; a recovery charge will be assigned.

CO-PAYMENT POLICY

Patients that carry health care insurance should remember that some policies require a co-payment for each visit. Consequently, it is your responsibility as defined by your policy to make these co-payments. Also important is that you are responsible for any and all supplies, such as braces and exercise equipment, which are provided to you and are not covered by your particular plan.

I understand that a \$35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).

I understand and agree that I am solely responsible for all deductible amounts, co-payments, and charges incurred which are not covered under my health care plan at the time services are rendered.

Please Initial _____

I hereby give authorization for payment of insurance benefits to be made directly to Canyon Physical Therapy & Aquatic Rehabilitation for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

APPOINTMENT POLICY

I have read and fully understand the Canyon Physical Therapy & Aquatic Rehabilitation Cancellation / No-Show Policy and agree to the terms.

Patient/Responsible Party Signature

Date

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

I do hereby consent to such treatment by the authorized personnel of Canyon Physical Therapy & Aquatic Rehabilitation as may be dictated by prudent medical practice for my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence. I authorize Canyon Physical Therapy & Aquatic Rehabilitation to release or obtain any medical or incidental information that may be necessary for physical therapy or in processing insurance claims. I authorize release of all records on request.

Patient/Responsible Party Signature

Date