Policies & Procedures

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CONSENT FOR CARE AND TREATMENT
I do hereby agree and give my consent for Skyline Physical Therapy, PLLC to provide medical care, evaluation, and treatment that is necessary and proper in diagnosing or treating my physical and medical condition.

NOTICE OF PRIVACY POLICY
I understand that my personal health information will be protected, and I can request a copy of the Notice of Privacy Policy.

REHABILITATION PROGRAM EXPECTATIONS

- Following your evaluation, your therapist will discuss your **diagnosis, treatment program and plan** as well as the **potential for improvement and frequency and duration** of your program.
- Normally, treatments can last from **30 minutes to 1 hour.**
- Please keep your therapist informed of your **next doctor visit**, so that we may share progress with your physician.
- Your **exercise program** will change as you progress. You will also be given a Home Exercise Program. Both programs are vital to your success. The **primary goal** of the program is to decrease pain, increase flexibility, strength and endurance, as well as general function. Another goal is to educate you and enable you to return to work, seek employment, or return to your previous level of activity.

Patients will be discharged from the program for the following reason(s): 1) goals are met; 2) compliance problems- exercise absences, tardiness, or lack of cooperation/poor motivation; 3) lack of progress or plateau; 4) other medical complications.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION
I hereby assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to Skyline Physical Therapy, PLLC. I understand that Skyline Physical Therapy, PLLC agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge, and the patient is responsible only for the deductible, co-payment not covered by any supplemental coverage, and any non-covered services including supplies. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Skyline Physical Therapy, PLLC to copy my driver's license to verify that I am the patient receiving the services and to release all information necessary, including Medical Records, to secure payment. I acknowledge that Skyline Physical Therapy, PLLC provided me with the opportunity to read a copy of the Notice of Privacy Practices and ask questions.

FINANCIAL POLICY STATEMENT
We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly pay Skyline Physical Therapy, PLLC. I understand that I am responsible for my co-payment, co-insurance, any services applied to my deductible, services not covered by my insurance policy, and for any services I choose not to submit to my insurance plan. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all the costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above does not apply for those patients that are on an HMO/PPO plan or considered Workers' Compensation; However, be advised if you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.

No Show and Cancellation Policy
No Show Policy: A patient who does not show for 2 consecutive appointments and does not phone to cancel the appointments is taken off the schedule for all remaining scheduled appointments. The patient remains a patient with Skyline Physical Therapy, PLLC and is welcome to make same day appointments.

CANCELLATION notice will be given 24 hours prior to scheduled appointment. In any given treatment period, cancellations for illness or unexpected emergencies can be expected. **Policy:** There is a $ 50.00 charge for a cancelled appointment with less than 24 hour notice. This fee is the responsibility of the patient and is due at the time of the next scheduled visit.

Signature of person completing this form ____ **Date** ________________

Relationship to patient: ______**self or** ____