PATIENT AGREEMENT FORM

GENERAL POLICIES

Thank you for choosing Corinthian Physical Therapy. To facilitate your treatment here we ask that you read and sign this agreement and authorization.

- A scheduled appointment must be cancelled at least **24 hours in advance**, otherwise a fee of *$100.00* will be charged. While we typically make efforts to confirm your appointments ahead of time, it is each patient's responsibility to keep track of their appointments regardless of whether you receive any reminder from us.

- Fees due to Corinthian Physical Therapy for co-payment, deductible, cancellation fees and treatment fees not covered by medical insurance are to be paid at the time of treatment or as otherwise agreed by Corinthian Physical Therapy.

- To the extent agreed by Corinthian Physical Therapy, we will submit bills to your insurance carrier on your behalf, as a convenience to you. However, in the event your insurance company does not cover all or any portion of your treatments, you are responsible for payment of all fees. If your carrier reimburses you, you agree to inform us of the receipt and pay us promptly.

Please note, we provide only Out-Of-Network physical therapy. We will provide bills for each of your visits, including, where applicable, insurance procedure codes for services you receive. If you would like, we will also contact your insurance company to try to verify your expected benefits, but this is not a guarantee of any payment. We cannot know the specific payment for services until payments are received, which, depending upon your coverage, can take several weeks from the date of submission. If the insurer denies all or part payment for any reason, we will do our best to provide relevant information and assist you in appealing their decision.

Please note that although we will make every effort to assist you with your insurance claims, patients are responsible for full payment for all services rendered by Corinthian Physical Therapy. For your convenience, we accept checks, cash or credit card payment.

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and request Corinthian Physical Therapy to provide such medical care and administer procedures and treatments as in the judgment of the physical therapists in attendance and deemed necessary and advisable.

AUTHORIZATION FOR RELEASE OF INFORMATION FOR INSURANCE BENEFITS

I hereby authorize and direct Corinthian Physical Therapy, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my care, all information needed to substantiate payment for my care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

EMAILS

Federal regulations require that anyone using email to communicate with healthcare providers understand and agree to the following conditions and limitations.

- The transmission of patient information via email has a number of risks including, but not limited to: email is not secure: email can be intercepted, misaddressed, altered, forwarded, or used without authorization or detection; email may be circulated, forwarded and stored in paper and electronic files even after the sender or recipient has deleted his or her copy.

- We will use all reasonable means to protect the security of the email; however, we cannot guarantee email confidentially. The Practice is not liable for improper disclosures unless they are caused by the Practice's intentional misconduct. I have read and understand the email disclaimer and give consent to Corinthian Physical Therapy to correspond with me via email, if necessary.

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to Corinthian Physical Therapy sufficient monies and/or benefits to which I may be entitled from insurance carriers or others who are financially liable to cover the costs of the care and treatment rendered to myself or my dependent by Corinthian Physical Therapy. I understand that I am financially responsible for all charges whether or not covered by my insurance or any other party.

* * *

I acknowledge and Agree to the information and each of the policies of Corinthian physical Therapy set forth above

_____ _____

Signature of Patient Date

_____

Print Patient's Name

DIRECT ACCESS LAW

Notice of Advice

The New York State Law Direct Access Law permits limited receipt of physical therapy services without needing a physician prescription or referral.

Treatments under this law are subject to the following:

1. You may have physical therapy for 10-visits or 30-calendar-days, whichever comes first. After this period a physician's prescription is required. If you do not have a physician, we can assist in finding the best doctor for your current needs.

2. Although the law recognizes your right to have freedom of choice in health care, your health insurance provider may require a prescription or referral in order for the services to be covered. If this is the case, you will be responsible for the fees.

I have read and understand this Direct Access Law Notice of Advice

Patient Name: _____

Patient Signature: _____ Date: _____