



Ivey

Physical Therapy & Sports Medicine

Caring Professionals - Quality Results

FINANCIAL AGREEMENT

I understand and agree that I am totally 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 matter of convenience 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 **Ivey Physical Therapy**, I will immediately deliver such payment directly to **Ivey Physical Therapy**. I agree also that, should the amount be insufficient to cover the entire physical therapy expense, I will be responsible to said physical therapists for payment of the difference; and that if the nature of the disability be such that it is not covered by the policy, I will be responsible to **Ivey Physical Therapy** for payment of entire bill. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. There will be a 1.5% late charge of any balance 30 days or over; once the insurance company pays. Should payment for services extend 60 days or beyond, I agree I will pay for those services personally and seek restitution from my insurance carrier. **Please initial** _____.

I hereby give authorization for payment of insurance benefits to be made directly to Sanderson/Ivey Physical Therapy 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.

Signature (Parent or guardian signature if patient is a minor) Date ____ / ____ / ____

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires consistent regular attendance to be optimally effective. **Please initial** _____.

APPOINTMENTS

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation. We require advance notice of 24 hours of cancellation. Failure to show for an appointment or cancellation without sufficient notice may be subject to a \$25.00 charge. **Please initial** _____.

CO-PAYMENT POLICY

Patients that carry health care insurance should remember that some policies require a copayment for each visit. Consequently, it is your responsibility as defined by your policy to make these copayments. 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. **Please initial** _____.

I understand and agree that I am solely responsible for all copayments and charges incurred which are not covered under my health care plan. I also authorize the release of any medical information necessary to process this claim. **Please initial** _____.

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which, in conjunction with the judgments of the attending physician, may be considered necessary or advisable for the diagnosis or treatment of the above named patient at **Ivey Physical Therapy**. **Please initial** _____.

Signature (Parent or guardian signature if patient is a minor) Date ____ / ____ / ____

Patient Name _____