

HPT Physical Therapy Specialists, Inc.

AUTHORITY TO EVALUATE AND PERFORM TREATMENT

I grant permission to HPT to perform treatment of physical therapy as deemed necessary by a Licensed Physical Therapist.

AUTHORITY TO RELEASE INFORMATION

I grant permission to HPT to release information concerning my physical condition to my insurance, attorney at law (with a current signed release), and any health care facility I may be transferred to or any health care facility from which I was referred.

AGREEMENT AND ASSIGNMENT

This date I have a contract with HPT Physical Therapy Specialists, Inc., 2240 5th Avenue, Huntington, WV 25703, for the furnishing of services rendered or to be rendered. I hereby direct my insurance to pay by check or electronic funds transfer payable to HPT without payment to me. I assign to HPT the rights to all present and future benefits due under my existing policy or policies of insurance.

VERIFICATION OF THIRD-PARTY BENEFITS

HPT does not accept third-party claims. We will consider your special circumstance, but please have other payment sources available.

PRE-APPROVAL FOR TREATMENT

I understand that I am responsible for obtaining pre-certification or pre-approval for treatment from my insurance carrier, if such pre-approval or pre-certification is required, and for charges not paid by my insurance carrier due to my failure to obtain such pre-approval or pre-certification. I understand the information given is merely a quote of benefits from my insurance company and I acknowledge that it is not a guarantee of payment. HPT is not responsible for ensuring payment from my insurance company. I agree to be an active participant in claims processing to ensure that there is no misunderstanding related to benefits or payment.

PAYMENT POLICY

AS A COURTESY TO YOU HPT WILL FILE YOUR CLAIM TO YOUR INSURANCE CARRIER, BUT YOU MUST HAVE THE PROPER ID CARDS OF ACTIVE INSURANCE, A DRIVER'S LICENSE OR STATE-ISSUED PHOTO ID, AND REFERRAL AT THE TIME OF SIGN-IN. WE WILL VERIFY WITH YOUR INSURANCE, PRIOR TO YOUR APPOINTMENT, THAT YOU ARE ELIGIBLE FOR BENEFITS.

MEDICARE PATIENTS: We require payment on the day of service for medical supplies, which are not covered by Medicare.

MEDICAID PATIENTS: WV Medicaid limits physical therapy to 20 visits per calendar year. Ohio Medicaid allows a maximum of 30 visits per twelve months from the evaluation date of service. KY Medicaid does not participate with private practices; therefore, treatment is not covered. You do have the option to pay for each visit at the time of service, but your insurance will not be billed. **THE MEDICAL CARD DOES NOT COVER MEDICAL SUPPLIES AND PAYMENT IS DUE THE DAY THAT MEDICAL SUPPLIES ARE RECEIVED.**

If deductibles are not met you will be expected to pay at the time of service 100% of the charges at each visit until your deductible has been satisfied. If your insurance company has not paid the balance of charges within 60 days of your visit, HPT will require the balance from you. I understand I am responsible for contacting my insurance carrier if payment is not made.

Claims rejected by Worker's Compensation will be your responsibility. The balance due will be your responsibility. You must provide us with the correct claim number and date of injury for proper billing.

Budget Agreements can be arranged. A minimum monthly payment of \$100 is expected within 10 days of the billing date on your monthly statement. If payments in the amount specified are not received on time the balance will be delinquent and due, payable immediately. I agree to pay all costs and expenses of collection, including reasonable attorney fees and court costs.

If unusual circumstances make you unable to meet our credit terms, call to discuss this matter with our billing department. We want you to keep your account in good standing. I give HPT the right to obtain a credit check. If my account becomes past due at any time for any reason, I agree to pay, for each month that it is past due, an additional \$10 per month.

I AGREE THAT I AM RESPONSIBLE FOR PAYMENT OF THE TOTAL BILL INCURRED AS A RESULT OF SERVICES RECEIVED. I, the undersigned, have read and understand the entire Consent to Treat form. I hereby agree to the terms therein.

Patient/Guardian Signature

Date

Witness/HPT Staff Member

Date