Hanneken
Full Potential
Physical Therapy & Rehab Services

AGREEMENT FOR SERVICE RENDERED

Insurance: Full Potential Physical Therapy (FPPT) participates with most, but not all insurance companies. Your insurance policy is a legal contract between you and your insurance company; we are not party to that contract. FPPT files insurance claims as a courtesy to our patients, but ultimately all charges are your responsibility. If your insurance changes, you must present a current insurance card to our Front Desk. If you do not have insurance, you will be required to pay in full at the time of service, unless other payment arrangements have been made with our billing department. FPPT may release your medical information and complete the usual and customary reports at no charge to you to obtain payment from your insurance company.

Based on your insurance coverage you may be subject to a deductible, copay, and/or coinsurance. You are expected to pay your copay at each visit. If a deductible or coinsurance applies, an estimated cost will be calculated by our billing department according to your insurance benefits; this amount will be collected at the time of service. This policy exists to relieve possible financial burden to our patients. As Physical Therapy is an ongoing treatment, patient portions can add up quickly. Please understand this is a service we provide to you as to avoid sending a large monthly bill. We want you to be able to concentrate on getting well, not on how you will pay your bill. If you purchase a supply, payment will be collected at the time of issuance. We do not accept returns for supplies purchased.

Preauthorization / Cost Estimates / Benefit Coverage: Our office will assist you to the best of our ability with pre-authorization requirements, cost estimates, and benefit coverage. We will relay this information to you as it is conveyed to us by your insurance company. Please note all Quotes of Benefits provided to you are just that, quotes. Your financial responsibility could be more, or less, than the Quote of Benefits provided.

Outstanding Balances, Past Due, and Unresolved Accounts: If there is a balance on your account, a statement will be mailed to you. This bill is expected to be paid within 30 days, unless a payment arrangement has been made with our billing department. If your account becomes past due and is forwarded to an outside collection agency, your account will be assessed a 20% collection fee based on your remaining balance. There will be a $25 service charge for all returned checks. If we have not received payment from your insurance company within 60 days of the date of service, we reserve the right to request payment in full from you.

Refunds: After all claims have processed, patient credits in an amount less than $25 will be retained on the patient's account. This credit will be used toward future balances, unless a refund is requested by the patient/guarantor. Credits greater than $25 will automatically be refunded to the patient/guarantor.

Cancellation and No-show Policy: Patients are expected to notify our office at least 24 hours before their scheduled appointment if they are unable to keep it. FPPT reserves the right to charge you fifty dollars ($50) for any missed appointment where a 24 hour notice was not provided for the cancellation. If we are not available via telephone, you may leave a voicemail message for the Front Desk (such as after hours and/or on the weekends). If there is a continued pattern of canceled appointments or no-shows, you will be discharge from therapy. If you desire to continue rehabilitation, you will be required to obtain a new prescription from your physician. Please note: This policy exists in the best interest of our patients. A 24 hour notice provides FPPT with the opportunity to find an appointment that works better for you, which will help us get you better faster. It also allows us to offer this opening to a patient who needs our help, and who may be on our cancellation list waiting to get in for treatment.

Consent to Treatment: By signing below, I hereby consent to the evaluation by a licensed Physical Therapist, and treatment of my condition by a licensed Physical Therapist or Physical Therapist Assistant employed by Full Potential Physical Therapy. The provider will explain the nature and purpose of the evaluation, procedures, and course of treatment. Also, they will inform me of the expected benefits, complications, discomforts, and risks that may arise from treatment. They will inform me of alternatives to the proposed treatment and the risk and consequences of no treatment, as well as provide an opportunity for me to ask questions.

I have read and understand the information above. I understand that I am financially responsible for all services provided to me, and all costs of collection incurred by Full Potential Physical Therapy. I agree to make payments at the time of service when a patient cost-share applies. I authorize the release of any medical information necessary to process my insurance claims. I understand that I am responsible for all amounts unpaid or not authorized by my insurance company, including the cost of supplies and cancellation/no-show fees. I consent to treatment as described above.

_____	_____
Printed Name of Patient/Legal Guardian	Date of Birth
_____	_____
Signature of Patient or Parent/Legal Guardian	Today's Date