GOOD HEALTH
PHYSICAL THERAPY & WELLNESS

Payment Policy and Consent to Treat

X_____Co-pays, Outstanding account balances, & Statements:

- Are due prior to treatment
- Payment plans are available upon request
- **Statements will be emailed by default.** If you would prefer to opt out of emailed statements, please select which method you would prefer instead:

X_____ Statement by mail **X_____** Statement by text

X_____ Billing

We must have a copy of your insurance card

- Benefits will be checked prior to your appointment. This does not guarantee payment from your insurance and ultimately you are responsible for payment
- If you have a secondary insurance we must be provided with the plan information
- Billed rates to insurance range from $240-$350, Patient responsibility will vary by each insurance contract and individual patient plan
- Billed Rates to insurance for Foot Orthotics will be $625.00 to $1250.00

X_____ Assignment of Benefits/Authorization to Release Medical Information, Consent to Treatment: I hereby assign all medical benefits to which I am entitled to Good Health Physical Therapy & Wellness in the event they file insurance on my behalf. I understand that I am financially responsible for all charges regardless of payment from my insurance. If my account becomes delinquent (over 90 days past due) and is therein default, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees of $20.00 per balance transferred, attorney's fee, and all court costs including additional legal fees associated with the recovery of this debt. All balances must be paid off within one year from the first date of service. I understand that there is a fee for all returned checks as allowed by state law. I hereby authorize said assignee to release all information necessary to secure payment of said benefits, and I do hereby consent to such treatment by the authorized personnel of Good Health Physical Therapy & Wellness as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

X_____ Privacy Practices: A copy of HIPAA policy & procedures have been provided.

X_____ Cancellation/No Show/Late Arrival Policy: Cancellation of a one hour appointment requires 48 hours prior notice. If an appointment is on a Monday, cancellation notice must be given on the Thursday prior.

Please see our full posted Cancellation, No Show, and Late Arrival Policy that includes associated fees. A copy of the policy for your records has been provided.

Patient Name_____ Date of Birth_____
Signature_____
Date_____

Parent/Guardian Name _____ Relationship: _____
(if applicable)