GOOD HEALTH

Self Pay / Time of Service

Payment Policy and Consent to Treat

Self pay/ Time of Service for Physical Therapy (Insurance Is not be billed)

- **Appointments are scheduled for 1 hour**
- **Self pay/Time of service rate is $155.00**
- **Payment is due at the time of service**
  - **We are unable to offer this rate and bill insurance during the same episode of care**

- **Fitness training (insurance is not to be billed)**
- **Appointments are scheduled for 1 hour**
- **Fitness training is $120 per hour, or 10 sessions for $1140 . Couple rate is $150 per hour, or $1350.**
- **Payment is due at the time of service.**
  - **We are unable to offer this rate and bill insurance during the same episode of care.**

I understand that I am financially responsible for all charges. 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. I understand that there is a fee for all returned checks as allowed by state law. 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 exception acts of negligence

Any statements you may receive 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

- ☐ **Privacy Practices: A copy of HIPAA policy & procedures have been provided**
- ☐ **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) _____