WEST BILLINGS PHYSICAL THERAPY PRIVACY STATEMENT

I, the undersigned patient and/or the responsible party have read and received a copy of West Billings Physical Therapy Privacy Statement.

FINANCIAL

West Billings Physical Therapy is happy to bill our patient's insurance carriers as a courtesy when they present with a current insurance card, however we are not contracted with all insurances, nor do we know your individual policy. It is ALWAYS the patient's responsibility to know their insurance carrier's benefits and policies.

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. In the case of non-payment by contracted/non-contracted carrier, patient is ultimately responsible for payment and follow-up with carrier for services rendered. I realize that failure to keep this account current may result in my being unable to receive additional services. In the case of default on payment, I understand that my account balance may be forwarded to a collection agency.

RELEASE OF MEDICAL INFORMATION

I, (we) orally or in writing, as may be requested, authorize the release and disclosure of any and all information regarding my condition when under your observation, treatment of care, including history, findings, treatment, x-ray readings and diagnosis and your prognosis. You are also authorized to allow my physical therapists to inspect and take a copy of your clinical or hospital records pertaining to me, and to inspect and borrow x-rays or photographs in your possession for examination.

I, (we) the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patient's medical records to any entity which is, or may be liable for all or part of the provider charges.

I, (we) authorize the release and disclosure of any and all my medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, (we) authorize the release of records necessary to assist in the reimbursement of benefits to which I, (we) may entitled. I, (we) authorize this office and/or its employees to release via fax machine, medical records which are needed in order to provide patient with the most appropriate medical care/payment for treatment rendered.

Y_____ N_____

Initial _____ Date _____

MEDICAL SUPPLIES AND ORTHOTIC

Many insurance companies do not consider medical supplies a covered benefit. Therefore, we ask for payment in full at the time of pick-up if you are purchasing a non-covered item.

LATE CANCELLATIONS AND NO SHOWS

Cancellations or changes must be made at least 24 hours prior to the scheduled appointment. If a patient fails to show for two scheduled appointments or cancels an excessive number of times, physical therapy will be discontinued and their physician will be notified.

I acknowledge that I have read and understand the policies as stated above.

_____ _____ **Date of Birth** _____

Signature **Date**