RESTORATION
PHYSICAL THERAPY

STATEMENT OF FINANCIAL RESPONSIBILITY

Restoration Physical Therapy, LLC appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any deductible and co-payment/coinsurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. **You are responsible for any amount not covered by your insurer.** If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full. **A monthly statement will be billed to you for any remaining balance.** The balance will be due 15 days from the billing date. A finance charge of $15 PER MONTH will be added to your balance 30 days past due.

CONSENT OF TREATMENT

I hereby authorize Restoration Physical Therapy, LLC through its appropriate personnel to perform, or have performed upon me, appropriate assessment and treatment procedures that may include manual techniques (manual stretches, dry needling, manipulation or kinesiotaping) and/or modalities (ultrasound, electrical stimulation, iontophoresis or traction).

PRIVACY PRACTICES

I have read and reviewed the notice of privacy practices act. (Ask the front office for a copy.)

I have read and agree to the above policies regarding my financial responsibility, consent to treatment, and privacy practices at Restoration Physical Therapy, LLC for providing rehabilitative services to the above named patient or me. I authorize my insurer to pay any benefits directly to Restoration Physical Therapy, LLC. I agree to pay Restoration Physical Therapy, LLC the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____**Date**: _____

(Relationship to Patient: Self - - Guardian - - Other: _____)

How did you hear about us?

☐ Doctor: _____ ☐ Friend: _____

☐ Online: _____ ☐ Other: _____