Hi- Desert Physical Rehabilitation Group
Office Policies and Financial Contract
With
Consent for Treatment

Welcome to our clinic. We want your physical/occupational/speech therapy needs to get the best and most efficient attention possible. A sound relationship between patient and therapist is based on a mutual understanding and commitment to several office policies. We have put them in writing because we live by them and in order for us to deliver a quality experience in our office we request that our patients live by them as well. We ask that you read this thoroughly to become familiar with them.

Treatment Philosophy

Therapy is a dynamic process requiring commitment to the schedule, dedication to the therapist's plan of care, and teamwork handling all contingencies. Our staff will guide you through the process, but a successful outcome requires your active involvement and participation on a consistent basis. We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, and more expense. With your participation in making this course of rehabilitation as productive and complete as possible, we will be able to reach the optimum outcome in the shortest time, without jeopardizing insurance benefits.

Financial Contract

We believe we have a responsibility to use our best professional care, skill and judgment in planning and delivering your therapy. We can only fulfill this responsibility through a bond of trust with you to pay for services. Therapy services provided to you as the patient consumer and therefore the fees for our services are charged to you regardless of whether or not you carry health insurance or are injured at work. For government or private health plans and for work injuries, we will contact the appropriate 3rd party to verify coverage, but ultimately it is your responsibility for obtaining authorization for treatment from your insurance company.

If this office is a contracted provider or if your insurer authorizes us to provide services, **you will be responsible for all co- payments, deductibles, or co-insurance amounts.** If this office is a contracted provider for your "managed care (HMO)" plan, we are obligated to collect from you the pre-arranged co- payment only and you are not obligated for any other amounts. Co-payments are set by your benefit plan and are due and payable at the beginning of each appointment. **If for any reason your insurance company does not pay, you will be accountable for the total charges for your therapy**.

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Attendance and Cancelation Notice

To best assure a productive course of therapy and a successful outcome, we are committed to scheduling your appointments in a manner suitable to the timely completion of your rehabilitative care. We will notify you as far in advance as possible of any necessary cancellation due to the sudden unavailability of the therapist. Appointment times do not carry over and must be schedule each week, unless other arrangements have been made with our receptionist.

We must have mutual respect for each other's time. An appointment put in our schedule with your name on it is a bond of trust that we will be here to serve you and that you will be present for that appointment. If there is a need to cancel an appointment we ask that you call to cancel. We ask for at least 24 hour notice. We do understand that life happens and emergencies may occur. Leaving a message on our machine does constitute as confirmation of a cancellation if you are unable to reach staff. (Please leave full name on the message)

There will be a $45 fee assessed to your account for failure to call to cancel an appointment. \If there is more than one appointment scheduled for that day and there was a no call /no show fee assessed it will be for each appointment.

Managed care and insurance companies cannot be billed for these broken appointments. A pattern of broken appointments and /or failure to give advance notification of cancelled appoints, may be grounds for insurances or workers compensation carrier to disallow treatment.

Release of Information

All information and records obtained during the course of your treatment shall remain confidential and **will not** be released without your written consent. If you are electing to use insurance , manage care, or workers compensation benefits, you are required to release confidential information to the benefit plan so as to process claims , for certification, case management, quality assurance, utilization, benefit administration or other purposes. If you do not want such information to be shared with your benefit plan, you may pay privately without using your insurance.

Consent to Treat

I hereby, consent to treatment by Hi- Desert Physical Rehabilitation Group. I further accept the above policies and financial arrangements, authorize Hi- Desert Physical Rehabilitation Group to furnish information to insurance carriers and assign all payments for services rendered to H.D.P.R.G. INC.

Patient Name:_____
Patient Signature_____ Date:_____
Witness Signature_____ Date:_____