SOL
PHYSICAL THERAPY

Patient Policy Form

Financial Consent:

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the bill when services are rendered. **All co-payments are due at the time of service, and the amount we are collecting is just an estimate of how your visit will process.** If, for any reason, the amount collected is not sufficient, there will be an outstanding balance; or, if the amount collected is over, there will be a credit on file. For any questions about your insurance benefits and/or limitations, **it is the patient's responsibility to contact your insurance provider.**

I understand and agree that, as a patient and/or guarantor, whether insured or a member of a health maintenance organization, in consideration of the services to be rendered, I hereby individually obligate myself to pay the account of the medical office in accordance with the regular rates, terms and interest (18% interest per annum on accounts thirty days past due) on the unpaid balance set out by the office. In the event that it is necessary to place the account with a collection agency to collect the balance due, an additional 35% of the principal balance due will be added. In addition, should legal action become necessary to collect the balance due, I understand that I will be responsible for, but not limited to, reasonable attorney's fees, interest and court costs. I also understand that if my account is placed with an agency for collection, or placed with an attorney for legal action, a credit report may be pulled for the sole purpose of collecting the delinquent account.

Our office will not be held responsible for misquoted benefits. **Please inform the front desk immediately if your insurance has changed.**

Initial here: ____________

No Show/Cancellation Policy:

Sol Physical Therapy requires a 24-hour notice if you will not be able to attend your appointment. If you fail to provide this notice, you will be charged a **$50.00 fee** for all same day cancellations or no-show appointments.

We value our patients' relationships and will do everything we can to accommodate you. Your communication and compliance are not only very much appreciated, but also will help us to help you and others achieve a positive outcome.

Initial here: ____________

HIPAA Patient Acknowledgement and Consent:

To comply with the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of our notice of privacy practices has been made available to you at our office front desk. Please check below if you would like to receive a copy of your own.

◯ Yes, please print me a copy ◯ No, I do not want a printed copy

(For Office Use Only)
Notice of Privacy Practices offered by: ________________________________

Consent for Treatment:

I hereby give written consent to be evaluated for my current diagnosis by a licensed physical therapist and treated by the same therapist and/or his/her physical therapist assistant employed by Sol Physical Therapy, and understand and agree to comply with the above terms of service.

____
Patient Name (Please Print)

________________________________ ________________
Patient Signature **Date**

________________________________ ________________
Parent or Guardian Signature (If Applicable) **Relationship**

Additional Information

How did you hear about SOL? ________________________________

Secondary Address ________________________________
(If Applicable) (City) (State) (Zip Code)

SOL
PHYSICAL THERAPY

Patient Name: ________________________________ **Date of Birth:** ____________

EMAIL & TEXT NOTIFICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to send you a billing statement, to obtain feedback on your experience with our healthcare team, or to provide general health reminders and information. The practice does not charge for this service, but standard messaging and data rates may apply, as provided in your wireless plan. Contact your carrier for details.

My preferred method of contact for the aforementioned notifications is: ◯ Text Message ◯ Email

☐ I would like to opt in to Sol Physical Therapy's monthly email newsletter.

I consent to receiving email and text notifications from Sol Physical Therapy.

Initial here: ___________

RELEASE OF INFORMATION

◯ **I do not wish to release any personal information to anyone**

◯ **I authorize Sol Physical Therapy to release the following information to my approved list of contacts:**

Approved List of Contacts:

________________________________ ________________________________

________________________________ ________________________________

Approved List of Contacts can (please mark any/all that apply):

☐ Obtain appointment times and make changes to my scheduled appointments

☐ Call and inquire about or obtain my billing information

☐ Pick up requested documentation

________________________________ ________________

Patient Signature **Date**

________________________________ ________________

Parent or Guardian Signature (If Applicable) **Relationship**

SOL PHYSICAL THERAPY

PATIENT RIGHTS AND RESPONSIBILITIES (AZ)

Patient Acknowledgement

The Arizona Department of Health Services (ADHS) licenses this office. As required by ADHS rules and other statutes, rules, and requirements, this office has a copy of your Patient Rights & Responsibilities posted in the lobby. If you would like a paper copy of your Patient Rights & Responsibilities provided for you please indicate below.

◯ **Per my request, I would like a paper copy of the Patient Rights and Responsibilities to take home with me.**

◯ **I decline a copy of the Patient Rights and Responsibilities.**

______________________________ ______________

Patient Signature **Date**

______________________________ ______________

Parent or Guardian Signature (If Applicable) **Relationship**