



## Statement of Office Policies

Welcome to MORE Physical Therapy, Inc.! We are pleased that you have chosen us for your rehabilitation needs. Please read this form in its entirety, initial each point to indicate your acknowledgment, and sign where indicated.

### **The staff and management of MORE promise to:**

- Welcome you to a caring and professional environment where you will receive the best standard of care at all times.
- Provide you with an individually designed treatment plan to meet your specific needs and goals.
- Answer any questions you may have.
- Do our best to respect your time by staying on schedule, as well as respecting your privacy and dignity during treatment sessions.
- Make no charges for appointment changes or cancellations where 24 hours notice has been given.
- Request authorization for services rendered, (when required) in a timely manner.
- Provide you with flexible payment options in order to insure continued access to quality treatment.
- Provide you with a dedicated Patient Account Representative who is available to assist you with insurance and payment concerns.

### **We appreciate your commitment to:**

\_\_\_\_\_ Being an active participant in your physical therapy treatment by arriving on time for appointments, informing your clinician of any concerns or questions you may have, and complying with home exercise instructions or other recommendations.

\_\_\_\_\_ Notifying us by phone 24 hours in advance if you must cancel or change an appointment. A \$50.00 fee will result when 24 hour advance notification is not given. This fee is not billable to insurance and must be paid prior to receiving any further services. This fee does not apply to workers compensation patients, however the adjuster will be informed of any missed appointments which may result in the denial of additional visits.

\_\_\_\_\_ Paying co-payments, where applicable, at the time of service. Patients without insurance are asked to pay in full at the time of each appointment. Failure to pay at the time of service may result in a billing fee of \$25.00 for each missed payment. We accept VISA, MasterCard, and checks. There will be a \$20.00 fee imposed for all returned checks.

\_\_\_\_\_ Knowing the provisions and limitations of your insurance coverage; and understanding that your policy is a contract between you and your insurance carrier.

\_\_\_\_\_ Understanding that your treatment plan is based on medical necessity as determined by your referring physician and/or MORE, not the limitations of your insurance policy; and requesting alternate treatment or payment arrangements if necessary.

\_\_\_\_\_ Providing us with accurate insurance information and the cause of your condition at the start of each episode of care, immediately upon changing insurance carriers, and/or when a new injury occurs.

\_\_\_\_\_ Paying MORE directly for any supplies ordered on your behalf at the time of receipt. Should you wish to seek reimbursement from your insurance carrier we can provide you with an itemized statement. Please note that supplies are not covered by many insurance plans.

\_\_\_\_\_ Paying any balance due on your account over 60 days past due regardless of insurance reimbursement status.

\_\_\_\_\_ Understanding that balances over 90 days past due will incur a 1.5% monthly charge (18% APR) and accounts over 120 days past due may be referred to our collection agency.

### **Authorization and Assignment**

I hereby authorize MORE Physical Therapy, Inc. to release information necessary to my insurance company in order to process claims for charges incurred by me, and I release MORE Physical Therapy, Inc. of any consequence thereof. In consideration of the services rendered to me by MORE Physical Therapy, Inc., I authorize and direct my insurance carrier to remit payment directly to MORE Physical Therapy, Inc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Agreement to Pay for Services Rendered**

(Not applicable for authorized Workers Compensation patients)

My signature below verifies that I have read and agree to the above-stated office policies, including an understanding that: Regardless of insurance coverage, I am responsible and liable for payment of all charges assessed for professional services rendered and any fees charged due to my failure to follow the above-mentioned policies. I am responsible for any balance due if my insurance company has not paid within 60 days. In the event that my insurance company remits payment to me for services rendered by MORE, I will promptly forward payment to MORE. If it becomes necessary for MORE to commence legal action for collection of any outstanding charges on my account, I will be responsible for all reasonable fees incurred to collect said charges including collection fees, court costs, and attorney fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Your feedback is important to us; whether it is praise or constructive criticism. Please visit our website at [www.morephysicaltherapy.com](http://www.morephysicaltherapy.com) to take our anonymous patient satisfaction survey. Paper survey forms are available for those patients without internet access.

*Help our practice thrive by recommending MORE Physical Therapy, Inc  
to your friends, family, and healthcare providers.*