



Pillars Physical Therapy
and Wellness Center

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OFFICE POLICIES

CONSENT FOR TREATMENT

I hereby consent to the evaluation and treatment by Pillars Physical Therapy and Wellness Center. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment. _____ (initial)

CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian, I authorize Pillars Physical Therapy and Wellness Center to treat the minor patient named. _____ (initial)

CANCELLATION AND NO-SHOW POLICY

If you are unable to make it to your appointment, call and leave us a message in the event we are unavailable. *Appointments missed or cancelled with less than 24 hr. notice will be charged a \$30.00 fee.* This fee is not covered by your insurance and is to be paid prior to your next treatment session. Letting us know ahead of time will allow us to re-allocate the time to someone else in serious need of treatment. _____ (initial)

Three consecutive missed appointments without notifying our office will be considered a valid reason for discharge due to non-compliance. Documentation of missed visits is included in your medical chart and is forwarded to your physician and/or case managers. _____ (initial)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Pillars Physical Therapy and Wellness Center to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Pillars Physical Therapy and Wellness Center. _____ (initial)

FINANCIAL POLICY

We will verify your physical therapy coverage prior to initiating any services and as a courtesy bill your insurance company to get your claims paid. However, it is your responsibility to fully understand your insurance coverage as it relates to the service you are about to receive and for any charges not covered by your plan. Some insurance require authorization prior to treatment and some have reimbursement limits on physical therapy services. We do not accept third party insurance, attorney or personal injury liens. _____ (initial)



In an effort to keep our fees low and your costs manageable for any charges not covered by your insurance plan:

Medicare Patients: I understand that if I do not have supplemental insurances, I will be responsible for the 20% co-insurance portion not paid by Medicare as well as my deductible. _____ (initial)

If your *deductible* is more than \$100.00 and the insurance company verifies that it has not been met, we will collect \$100.00 at the time of service and thereafter until your deductible has been met. If at the end you have over paid, we will reimburse you once your insurance company has fully processed the claim. _____ (initial)

If you have a *co-insurance* of 30-60%, we will collect \$40.00 prior to each time of service. *Note that this amount is only a portion of your balance.* Actual patient responsibility can only be determined once your insurance company has fully processed the claim. _____ (initial)

Your *co-payment* is collected *prior* to each treatment. _____ (initial)

On occasion and depending on your insurance plan, our out of pocket fees may come out cheaper than certain insurance deductibles, co-insurance and co-pays combined. Once a decision has been made to bill your insurance, we will not be able to revert to the out of pocket pre-paid or per service discounted rates. _____ (initial)

I understand that if it is necessary to employ a collection agency and/or attorney to enforce or to collect a judgment based on this agreement, the patient will be responsible for payment of the fees promised including interest, court costs and attorney fees. _____ (initial)

You and only you are ultimately responsible for your health, the health insurance you choose, the medical services rendered to you and the financial responsibility that comes with it.

I have read, understood and accepted the terms of this agreement, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this agreement.

Printed Patient Full Name

Printed Parent/Guardian Name
(If patient is a minor)

Patient Signature

Parent/Guardian Signature

Date Signed



**Notice of Privacy Practices for Protected Health Information
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Consent and Acknowledgement**

The Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form are kept properly confidential. This gives you the patient, rights to understand and control how your health information is used.

By signing this consent form I authorize Pillars Physical Therapy and Wellness Center to use my protected health information to carry out the following:

- Treatment
- Obtaining payment from third party payers (insurance company)
- Day to day health care operations of your practice

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or other healthcare operations, but that you are not required to agree to these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

I, the undersigned, acknowledge with my signature that I have received a paper copy of the Notice of Information Practices and hereby consent to the use and disclosure of my health information for purposes noted.

Printed Patient Full Name

Patient Signature

Printed Parent/Guardian Full Name if patient is a minor

Parent/Guardian Signature if patient is a minor

Date Signed