KETHLEY
Physical Therapy

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CONSENT FOR TREATMENT

Welcome to Kethley Physical Therapy.

It is the policy of Kethley Physical Therapy to file your health insurance as a courtesy and convenience to you. Once you have given us your policy information, we will call your insurance company to verify you physical therapy coverage. Please be advised that the information your insurance company provides to us is <u>only a quote</u> of your benefits and <u>not a guarantee of payment</u>. Our estimation of your financial responsibility (co-pays, percentage due, etc.) is based on the benefits quoted before your claims are submitted to your insurance company. It may be necessary to adjust the amount due once an actual explanation of benefits is received from your insurance company.

In addition, your insurance company has developed maximum fee schedules for rehabilitation and other services. These schedules are internal to your insurance company. These fee schedules are called "usual and customary" benefits. If you think your insurance company has made inadequate payment on your account, please contact them to discuss the matter.

As always, we will strive to provide you with accurate and current information. However, we recommend that you contact your insurance company directly if you have any questions or concerns regarding your insurance coverage.

Durable Medical Equipment (DME):
Payment for any DME that your physical therapist provides is expected at the time you receive the item. These items may include, but are not limited to therabands, hot/cold packs, SI belts, braces, etc. You may request a receipt for the item you purchase to submit to your insurance company for reimbursement. It is your responsibility to know if the item is reimbursable by your insurance company.

Cancellation/No Show Policy:
We respectfully request that if you must cancel an appointment, please call us 24 hours in advance. Otherwise, we must charge you a $15 cancellation fee.

Consent for Treatment:
I understand, consent and agree that I will be seen, evaluated and treated by a licensed physical therapist. I further understand that I may also be seen upon occasion by a fully trained and qualified associate under the guidance and direction of the licensed physical therapist.

________________________________   ________________
Patient/Guardian Signature   Date

________________________________   ________________
Witness   Date