Total Physical Therapy

6933 S. 66th E Ave. Tulsa, OK 74133 Phone# 918-495-0600 Fax# 918-496-2146

PAYMENT POLICY & BILLING PROCEDURES

1. I hereby authorize and request that payment of benefits by my primary and secondary insurance (if any) be made directly to **Total Physical Therapy** for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. In addition, I authorize Total Physical Therapy to disclose any and all written information from the above-named insurance company and/or its designated representatives for reimbursement purposes for those services received. I hereby release **Total Physical Therapy**, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company(s) or their designated representatives.

2. I understand that, unless 100% coverage has been verified, I am responsible for the percentage &/or deductible not covered by My insurance company. This payment is requested during each visit.

2. I understand that if insurance information is not available or I do not have insurance, **payment is due in full** unless other arrangements have been approved by our Centralized Billing Office (CBO.)

3. I understand that there is a $25 charge for all returned checks.

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance, however; we cannot guarantee payment. We strongly suggest that you read you policy manual as it pertains to physical therapy coverage. Many insurance companies have stipulations, such as usual & customary fees (UCR), limited therapy sessions, limited reimbursable amounts per session, deductibles, co-payments, supplies, etc. Such stipulations should be indicated in your policy manual.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED by your insurance. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.

Worker's Compensation benefits will be verified, however; this does not guarantee payment. In the event of denial, this account will become **YOUR RESPONSIBILITY.**

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitation treatment and care to a Total Physical Therapy Outpatient Rehabilitation Center. Total Physical Therapy has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and /or recommended by my therapist. By signing this agreement, I consent to have Total Physical Therapy Outpatient Rehabilitation provide treatment and care as prescribed and care as prescribed by my physician and/or recommendation by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payments policy & billing procedures of Total Physical Therapy Outpatient Rehabilitation. I hereby authorize Total Physical Therapy Outpatient Rehabilitation to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign Total physical Therapy Outpatient Rehabilitation all money to which I am entitled for medical expenses related to money received from the above-named parties over & above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Total Physical Therapy Outpatient Rehabilitation for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.

Total Physical Therapy does not discriminate against any person based on race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, or in employment. For further information about this policy, contact Curtis M. Hobbs, (918) 495-0600.

Signature:	**Date**

Relationship to Patient (self, parent, guardian, spouse, etc.):

Witness: