WELCOME TO BECHTEL PHYSICAL THERAPY

Carefully read the following information. If you have any questions, please do not hesitate to discuss them with us.

PAYMENT POLICY:

We have verified your insurance benefits and will be happy to bill your primary insurance carrier for you. Please remember, however, that you are ultimately responsible for payment of all services rendered to you. It is also your responsibility to confirm that your policy will cover physical therapy and to know if any limitations apply. At each visit, you will be asked to pay your estimated portion (co-payment and/or deductible) for the treatment. For your convenience, we accept MasterCard and Visa. (Any check returned by your bank for non-sufficient funds is subject to a $20.00 service charge.) Please let us know if you have already had physical therapy or chiropractic treatment this year, as it may affect the number of sessions your insurance company will pay for.

Signed: _____ **Date**: _____

CANCELLATION POLICY:

We would greatly appreciate 24 hours' notice if you are unable to keep your scheduled appointment. When our office is closed, you may cancel an appointment by leaving a message on our voice mail service. Appointments cancelled for non-emergency reasons with less than 24 hours' notice may be subject to a $75.00 cancellation fee. If you arrive more than 15 minutes late for your scheduled appointment, it may be necessary to cancel your appointment.

Signed: _____ **Date**:_____

FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for all fees incurred for my (or my child's or legal ward's) treatment even if I have insurance which covers all, or part of the cost of the treatment. BPT is not obligated to collect your insurance claims or negotiate settlements on disputed claims. I agree to pay a finance charge of 1% per month (or any lawful lower sum) on any balance due which remains unpaid for 60 days or more. I understand that, where appropriate, credit bureaus may be contacted concerning my account.

Signed: _____ **Date**:_____
(Patient or Legal Guardian)

CONSENT TO TREAT:

I authorize Bechtel Physical Therapy to provide physical therapy services to me/my child my/ legal ward.

Signed: _____ **Date**: _____
(Patient or Legal Guardian)

AUTHORIZATION:

I hereby authorize Bechtel Physical Therapy to furnish to my insurance carrier(s) any and all requested information concerning my health care. I also authorize my insurance carrier(s) to pay Bechtel Physical Therapy (Teresa Bechtel-Greenberg, PT) directly for any services rendered.

Signed: _____ **Date**: _____
(Patient or Legal Guardian)