**FINANCIAL REPSONSIBILITY AND AUTHORIZATION TO PAY BODIES IN MOTION PHYSICAL THERAPY, INC.**

Privacy Officer – Colleen O'Kane 650-947-9914

I hereby authorize my insurance benefits to be paid directly to Bodies in Motion Physical Therapy, Inc. for in network insurance. For out of network I understand I will pay the PT fee at the time of service and Insurance reimbursements will be paid directly to me. I understand that I am financially responsible for all amounts not covered by Insurance, including deductibles: co-payments, cash pay, and continued treatment and services when insurance benefits are exhausted, or benefits or if benefits are cancelled at any point during rehabilitation. I authorize Bodies In Motion Physical Therapy Inc. to release any information necessary to process my medical claim. I understand that charges for all services provided to me or my child/children by Bodies In Motion Physical Therapy, Inc. which are not covered by my insurance are my personal responsibility. My signature below constitutes my agreement to pay for such services. I acknowledge that I am responsible for payment of all services that my insurance does not cover and it is my responsibility(and not Bodies In Motion Physical Therapy Inc.) to know and understand the extent of my health insurance coverage. Payment is required at time of service for co payments and deductibles or a $10.00 fee per visit will be charged. Should there be a remaining balance after your insurance company has paid their portion; uncovered amounts shall be paid within 30 days of the date of the billing statement. After 30 days, a late fee of $10.00 per visit will be assessed. After 60 days, your account may be transferred to a collection agency.

The fee for a returned check is $35.00 in addition to the amount of the check. This charge covers our bank fee as well as additional processing and billing costs. As a service to you we will bill your Insurance carrier. We will make two(2) attempts to bill and re-bill for the correct payment. Should our efforts be unsuccessful, you will be responsible to pay for the services. We will Provide you with the forms and codes needed for you try an obtain reimbursement(s) from your insurance carrier. An appointment cancellation fee of $50.00 will be charged for appointments cancelled with less than 24 business hours prior to the scheduled appointment time. In the even it is necessary to assign the account to a collection to a collection agency or if legal action is necessary to enforce the terms of this agreement. I agree to be responsible for all fees and costs incurred by Bodies In Motion Physical Therapy Inc. including attorney's fees. My signature below constitutes an agreement to adhere to the financial responsibilities outlined in this agreement.

_____ _____

Signature Relationship to patient Date

**CONSENT TO TREATMENT**

I understand that I will be receiving treatment by physical therapists and support staff at Bodies In Motion Physical Therapy, Inc. I will have the chance to ask questions and have received satisfactory answers regarding my treatment program.I agree to be an active participant in my physical therapy and or /fitness program. My signature below indicates that I have received the information needed to consent or refuse treatment at Bodies In Motion Physical Therapy, Inc..

_____ _____

Signature Relationship to patient Date

**Acknowledgement of Receipt of Notice of Office Privacy Practices**
**Privacy Officer- Colleen Okane 650-947-9914**

I hereby acknowledge that I have had the opportunity to review a copy of the clinics Notice Of Privacy Practice for my review. I further acknowledge that I have the right to a copy of the current Notice of Privacy Practices as well as any amendments made to the notice. I also acknowledge that a copy of the current Notice will be in the reception area for my review. I also understand that my email is utilized for appointment reminders and to receive information about Bodies In Motion Physical Therapy, Inc. My personal information and Email is not given to any other person or entity without my written consent.

_____ _____

Signature Relationship to patient Date

Revised date: 04/2017