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

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 that 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 if benefits are denied 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 insurance are my personal responsibility. My signature below constitutes my agreement to pay for such services. I acknowledge that I am responsible for payment for all services that my insurance does not cover and that it is my responsibility (and not Bodies In Motion's responsibility) to know and understand the extent of my health insurance coverage. Payment is required at the time of service for co-payments and deductibles or a $10 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 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 in addition to the amount of the check. This charge covers our bank fees 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 to try to obtain reimbursement from your insurance carrier. An appointment cancellation fee of $75.00 will be charged for appointments cancelled less than 24 business hours prior to the scheduled appointment time. In the event it is necessary to assign the account to a collection agency or if legal action is necessary to enforce the terms of this agreement, I agree to be responsible to all fees and costs incurred to Bodies In Motion Physical Therapy, Inc. including attorney's fees. My signature below constitutes agreement to adhere to the financial responsibilities outlined in this agreement.

_____ _____
Signature of Patient or Responsible Party Date

Consent to Treatment

I understand that I will be receiving treatment and physical training by physical therapists at Bodies In Motion Physical Therapy, Inc. I will have the opportunity 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 to or refuse physical therapy & I authorize and consent to receive physical therapy at Bodies In Motion Physical Therapy, Inc.

_____ _____
Signature of Patient or Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices
Privacy Officer-Colleen O'Kane 650-282-5554

I hereby acknowledge that I have had the opportunity to review a copy of the clinic's 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 of Patient or Responsible Party Date

Revised 4/03/2019