

PAYMENT FINANCIAL AGREEMENT

Our relationship is with the patient. The patient is ultimately responsible for payment of services. We call the patient’s insurance company, as a courtesy, to get benefits and will discuss benefits with the patient and/or payer of services. **We collect deductibles in full.** If the patient has co-insurance, we collect an **estimated amount weekly** to go towards the co-insurance and will balance bill when insurance processes. **Copays are expected to be paid at time of visit.**

Signature of responsible party\parent\guardian _____ Date _____

VOICEMAIL

Do we have your permission to leave voicemail messages regarding appointments or your account on the numbers you’ve provided us?

Please mark: Yes ___ No ___

Signature _____ Date _____

CARE AND CONSENT

I hereby agree and give my consent of care to Jones Physical Therapy. If under 18 years of age, responsible party must sign.

Signature _____ Date _____

I have received and read a copy of Notice of Privacy Practices (HIPAA)

Signature _____ Date _____

We require 24 hour notice in the event of a cancellation. If 24 hour notice is not given, we reserve the right to charge a cancellation fee.

Signature of employee that collected patient paperwork _____ Date _____
