Amelia Physical Therapy
Permissions and Terms Form
(Returning Patients)

10130 Superior Way
Amelia, VA 23002

116 E. Broad Street
Blackstone, VA 23824

Amelia Physical Therapy believes that a good physical therapy practice involves open communication. We are dedicated to providing the best possible physical therapy services for you, and we want you to have a full understanding of our terms and policies.

1. **CONSENT FOR PHYSICAL THERAPY SERVICES:** I voluntarily consent to receiving physical therapy services for myself and/or my dependents and request Amelia Physical Therapy, Inc. to provide these services to me and/or my dependents on behalf of or as prescribed by our physician.

2. **RELEASE OF MEDICAL RECORDS:** I authorize the release of any and all medical records to Amelia Physical Therapy as needed for insurance, payment processes, or to further my rehabilitation.

3. **INSURANCE:** As a courtesy to our patients, Amelia Physical Therapy makes every effort to verify insurance coverage; however, our verification is not a guarantee of benefits payable by your insurance.

   I understand Amelia Physical Therapy Inc. will submit a claim for payment to my insurance company and therefore needs to maintain current insurance information. I agree to provide all updated insurance information and/or a copy of my new insurance card to Amelia Physical Therapy Inc. as needed.

   I recognize that it is my responsibility to be aware of my policy details and limitations regarding outpatient physical therapy. I understand that if my insurance plan requires a referral, I must obtain a referral in order for the services provided to me by Amelia Physical Therapy Inc. to be covered by my insurance.

   Assignment of insurance benefits: I request that payment of authorized insurance benefits for services be reassigned and paid directly to Amelia Physical Therapy, Inc.

   I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

4. **RELEASE OF INFORMATION:** I hereby authorize Amelia Physical Therapy Inc. to furnish/release information concerning my condition and treatments (verbally or in writing) including confidential medical information to any person, entity, government agencies, insurance carriers, or others who are financially liable to Amelia Physical Therapy Inc. for charges for physical therapy services and supplies, and for quality management, utilization review, transfer of medical care, and follow up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.

5. **RESPONSIBILITY FOR PAYMENT:** In the event my insurance carrier/company denies the services provided to me by Amelia Physical Therapy Inc. and/ or fails to pay for the entire cost of services as required, I understand that I, personally, am financially responsible to Amelia Physical Therapy Inc.

   I agree to pay Amelia Physical Therapy Inc. for services and supplies if my insurance does not pay or if my insurance benefits are paid directly to me inadvertently. ***Signature Required on Back***

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I understand that if I do not have a valid referral and still wish to be seen, I am required to pay in full at the time of service.

I understand that I am responsible for a return check fee of $35.00 if payment made by my personal check is returned to Amelia Physical Therapy Inc. due to insufficient funds

I understand that any balance remaining on my account after 60 days from the date of services is subject to interest charges at the rate of 1.5 percent per month.

Collection Fees: If my account goes into a collection status due to non-payment, I authorize the release of my personal information needed to successfully collect the outstanding balance I owe. I agree to pay all fees, including registered mail fees, court costs, and attorney fees of 33%, incurred as a result of these collection efforts.

6. **NO SHOW POLICY:** I understand that I will be charged a $25.00 fee if I fail to provide at least 24 hours' notice if I must cancel an appointment. I understand that Amelia Physical Therapy Inc. reserves the right to place me on a "same day only" list for future appointments after 3 cancelled visits or no shows.

7. HIPAA: I am aware that a notice of Amelia Physical Therapy Inc.'s Privacy Practices is posted in the waiting room and a copy is available upon request. I give permission to discuss medical treatment or give medical information to the person(s) listed below.

Name Relationship to patient

Name Relationship to patient

I have read, understand and agree to be bound by Amelia Physical Therapy's permissions and terms outlined in this document.
I also understand and agree that such terms may be amended by Amelia Physical Therapy Inc. at any time.

_____ _____

Patient Signature/or Responsible Party Date

_____ _____

Patient/Responsible Party Printed Name & Birthdate Witness

Address:	City/State/Zip:
Phone #:	Email:
Social Security #:	Employer:
Emergency Contact:	Emergency Phone #:
Email or Text Reminder? Circle one or none.	If text reminder, provide Carrier:

Name of referring doctor and date of next follow up: _____