



**Strive Physical Therapy, LLC.
Consent for Care and Treatment**

I, the undersigned, do hereby agree and give my consent for **Strive Physical Therapy** to provide evaluation and treatment by a physical therapist to:

Patient / Guardian

Signature _____ **Date** _____

Assignment and Release

I hereby authorize my insurance company to pay benefits directly to Strive Physical Therapy and I am financially responsible for non-covered services including supplies. I also authorize Strive Physical Therapy to release my information to: Doctor(s), Insurance Company(s), Attorney(s), as listed below.

_____	_____
_____	_____
_____	_____

Signature _____ **Date** _____

Financial Policy Statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when the services are rendered. **All Co-pays are due at time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you.** If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to you for services billed by us, and /or you have given Strive Physical Therapy a Lien, you recognize an obligation to promptly remit the same to Strive Physical Therapy. All lien cases will be balance billed and interest will accrue until the case is settled unless insurance contracts obligations prevent this. If this account is referred for collection, I agree to pay collection fees up to 50% on the balance owing. If legal action is deemed necessary, I agree to pay reasonable attorney's fees and court costs in addition to the above costs.

This does not apply to those patients who are considered under **Worker's Compensation**. However, be advised as a Compensation patient that you may be held responsible for your charges in the event your claim is controverted. If patient has secondary insurance coverage, Strive Physical Therapy will do their best to get payment from that company. If after two attempts to settle a claim without results, it will become the responsibility of the patient to pay their account in full and handle the secondary claims.

Patient agrees to pay interest at the rate of **12% per annum** on all outstanding fees, commencing 30 days after billing.

Note: Estimated coverage information is provided as a courtesy to our patients by their insurance company. Strive Physical Therapy will not be held responsible for misquoted benefits. It is the patient's responsibility to know their insurance coverage and benefits. This includes authorization required by the insurance company for physical therapy treatments. This estimate does not release the patient's responsibility for the total account balance.

It is the patient's responsibility to schedule appointments. We recommend you schedule in advance, there are no "standing" appointments. Check with the desk before you leave each appointment.

Note: Our cancellation policy is 8 hours notice.

A \$50 fee will be charged for no show/no call appointments.

I have signed a copy of the cancellation policy.

Estimated Patient Payment: **Patient is responsible for all deductibles, co-pays, and % co-insurance amount upon verification.**

The above information has been explained to me. I understand my responsibility for the payment of my account.

I give permission to **accept** text messages and or emails regarding my care (initial) _____

PATIENT or RESPONSIBLE PARTY

DATE

Strive Physical Therapy 3116 N Swan Rd, Tucson, AZ 85712 Ph: 520-829-7390 Fax: 520-829-7393

05/10/2021