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 / Parent / 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), Family members, 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 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.
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.

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 estimate does not release the patient's responsibility for the total account balance. This includes authorizations that may be required by your insurance company to receive physical therapy treatments. If your condition uses the full amount of the Medicare allowed visits, our policy along with Medicare guidelines, require a signed **Advanced Beneficiary Notice** from Medicare that will allow you to choose further treatment options from Strive Physical Therapy. If we bill Medicare first, it will be considered your Primary insurance regardless of secondary coverage you may have. *Your care must be determined to be medically necessary to be covered by Medicare and under the care of a physician.*

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.

Estimated Patient Payment: **20% of Medicare allowed amount up to $2,110.00 yearly outpatient physical therapy limit. Supplemental insurance *may* cover the 20%. The patient is responsible for balance remaining, including charges not covered by Medicare.**
The yearly Medicare deductible of $203.00 is the responsibility of the patient.

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. _____

_____ _____

PATIENT or RESPONSIBLE PARTY **DATE**

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

01/03/2021