PAYMENT/BILLING POLICIES

Revitalize Physical Therapy LLC is a fee-for-service clinic. This means that payment is due at the time services are rendered and we will not bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may choose to submit to your insurance company. If further reports or documentation are requested, these will be provided. We accept cash, personal checks, and credit cards.

Medicare will not pay for our services as we are *not* a Participating Provider with Medicare or any other insurance company, and we only agree to work with Medicare clients for fitness, prevention, and wellness goals (which are not covered services under Medicare). Medicare will not pay for services rendered at Revitalize Physical Therapy LLC. You will not be able to submit for reimbursement as our services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually possess.

Since you will be paying at the time of service, any reimbursement received by Revitalize Physical Therapy LLC from your insurance company will be returned to them and requested it be reimbursed to you directly.

We are available for after hours, weekend, and home visits at additional costs. Supplies and additional items are also at additional costs. Please clarify prior to your first treatment if you have any questions regarding charges or fees. If you need to cancel an appointment, we do require 24-hour notice prior to your appointment otherwise you may be charged a cancellation fee, equivalent to a treatment session fee.

CONSENT TO PHYSICAL THERAPY

1**. CONSENT TO TREATMENT**: I consent to physical therapy services at Revitalize Physical Therapy LLC. In doing so, I understand, acknowledge and affirm that such services may involve bodily contact, touching, and/or direct contact of a sensitive nature.
2. **TREATMENT OF MINORS**: I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
3**. LIABILITY**: I know and agree that Revitalize Physical Therapy LLC is not responsible for loss or damage to personal valuables.
4. **WAIVER AND RELEASE**: I hereby release, discharge and acquit Revitalize Physical Therapy LLC, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.
5. **AUTHORIZATION OF PAYMENT**: I have read and understand the billing policy for Revitalize Physical Therapy LLC and acknowledge that payment is required at time of service. I understand it is my responsibility to submit for reimbursement to insurance and if I carry Medicare, it will not be covered.
6. **CANCELLATION POLICY**: I have read and understand the cancellation policy and acknowledge that there may be a cancellation charge if there is not 24-hour notice given.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Date: _____

PATIENT INFORMATION CONSENT FORM

Disclosure Authorization – For Release of Protected Health Information (PHI)
I understand that Revitalize Physical Therapy LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. A copy of the Notice of Privacy Practices is available upon request.

Patient/Guardian Signature: _____ Date _____

Communication of Health Information
I give permission to Revitalize Physical Therapy LLC to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I wish to be contacted in the following manner(s):

Home Telephone
☐ OK to leave message with detailed information
☐ Leave message with call-back number only
☐ OK to leave message with family members or other persons living in the same household

Cell Telephone
☐ OK to leave message with detailed information (for appointment reminders)
☐ OK to text message with detailed information (for appointment reminders)
☐ Leave message with call-back number only

Email (Please specify email address) _____
☐ OK to leave message with detailed information (for appointment reminders)
☐ I would not like to be contacted via email

Patient/Guardian Signature: _____ Date: _____