Dresher Physical Therapy
Orthopedic • Post-Operative • Sport • Spine

STATEMENT OF FINANCIAL RESPONSIBILITY

Dresher Physical Therapy is proud to serve your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. You are, however, ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and copayment/coinsurance as determined by your contract with your insurance carrier. Payment is expected at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance denies any part of your claim, or if you and your physician elects to continue therapy past the approved period, you will be responsible for the account balance in full.

I have read the above policy and agree to pay Dresher Physical Therapy the full and entire amount of any bills incurred, or if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____
(If the guarantor is not the patient)

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dresher Physical Therapy to perform, or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures relating to the diagnosis which has brought me to therapy. I further authorize Dresher Physical Therapy to release to appropriate agencies any information acquired in the course of my or the above patient's examination and treatment.

Patient Signature: _____ Date: _____
(Or parent, if the patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read or had the opportunity to read a copy of the Notice of Privacy Practices (HIPPA) and understand the Notice. I was given a copy of the Notice for my records if I so requested.

Patient Signature: _____ Date: _____
(Or parent, if the patient is a minor)