Revitalize Physical Therapy at Foot and Ankle Centers

Physical Therapy Appointment & Financial Policy

A Message to Our Patients:

Thank You for choosing **Revitalize Physical** Therapy where communication between Physician, Therapist and Patient is our highest priority.

Your attendance and commitment to physical therapy is important, in maximizing your outcome. Your therapist will perform an evaluation and make a plan of care with appropriate goals. Please advise the Therapist when follow-up appointments with Dr. Rappette, Dr. Pandya or your referring physician, are scheduled for reassessments to be completed.

I agree to allow students to observe during physical therapy treatments.

To assist in communication please provide an e-mail address
_____@_____

Family Member Observation

Please allow the Physical Therapist to direct all treatment, care, and focus directly on the patient.
Please refrain from correcting patient during treatment sessions.

CANCELATION

We require a 24-hour notice during business hours to avoid a **$50 cancellation fee.**
Please call physical therapy department for all cancellations 630-553-2092

Please sign below to acknowledge you have read and understand our appointment policy.

CONSENT

* I (or the person responsible for consenting on the patient's behalf) consent to examination, treatment and other services provided by the doctors, their associates, or physical therapy staff. I authorize Centers for Foot & Ankle Surgery, Ltd to release to my insurance company or its representatives, any information regarding my diagnosis or records of any treatment or examination rendered to me that is required to process my claims.* I authorize & request that my insurance company pay directly to Centers for Foot & Ankle Surgery, Ltd. the amount due me in pending claims for medical treatment or services, by reason of such treatments or services rendered to me until revoked in writing**. I understand I am directly responsible for services rendered and not paid by insurance.**

* I understand that the information provided on this form is true & correct to the best of my knowledge.
Thank you very much for your cooperation,

Revitalize Physical Therapy

_____

Print Patient Name If not patient state relationship Date

_____

Patient signature

Revitalize Physical Therapy Financial Policy

Patient's Financial Responsibility:

Our office contacted your insurance carrier, the benefits **provided** to us for Physical Therapy are an **estimate** of patient responsibility, and it is ***never a guarantee of payment***.

NOTE: When our office calls - not all insurances provide us with **all** of the patient's financial responsibility such as deductibles, or co-insurance (percent patient is responsible for paying) of co-payments.

Our office accepts the allowed amount of approved coverage. Patient is responsible for deductibles, co-insurance or co-payments.

Deductibles, co-insurance and co-payment are expected at time of service. For minors attending therapy sessions without a parent or guardian, payment will be due via check, parent/guardian calling with credit card information, charging a card left on file or from the minor at time of service.

_____ _____

Signature of patient/guardian Today's date

PLEASE provide Original to patient after Scanned