EXCEL
PHYSICAL THERAPY & REHAB

3323 Shattuck Road, Suite # 2
Saginaw, MI 48603
Tel: (989) 341-1919
Fax: (989) 341-1920
www.excelptmi.com

Financial Policy and Consent to Care

Thank you for choosing Excel Physical Therapy & Rehab, PLLC for your Physical Therapy needs. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Payment Policy

Your contract for health insurance is between you and your insurance company. We are not a party to that contract. Physical therapy services that you receive and the bill is an agreement between you and Excel Physical Therapy & Rehab, PLLC. Agreements with insurance companies vary greatly and it is your responsibility to know what your insurance covers and what portion you are responsible for. Our office staff will be happy to assist you in obtaining this information. We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so, on a weekly basis. However, your physical therapy bill including all co-pays and deductible is ultimately your responsibility. An itemized statement of physical therapy services and insurance reimbursement along with any balance will be sent to you. It is your responsibility to pay the balance within 30 days of receiving such statement. Any account that is more than 45 days overdue is considered delinquent and will be turned over to a collection agency that will affect your credit rating.

Authorization for Release of Information

I hereby authorize the release of information of any medical records for the purpose of financial reimbursement to Excel Physical Therapy & Rehab. I request that payment be made directly to Excel Physical Therapy & Rehab for the services rendered. I consent to the release of any medical records to be reviewed by authorization representation of Medicare, Medicaid, Blue Cross Blue Shield/Blue Shield of Michigan, and/or my private insurance carrier.

Consent for Care

I hereby consent and authorize Excel Physical Therapy & Rehab to provide care and carry out all procedures as prescribed by my physician in the plan of care established. A representative of this organization has explained my plan of care and answered all of my questions satisfactorily.

Absentee Policy

Due to large volume of patients seen at this practice, it is the patient's responsibility to arrive on time for their scheduled appointments. Patient who is more than 15 minutes late without a valid reason will be rescheduled. Cancelled appointments with less than 24 hours notice will attract a charge of $15.00 that is patient's responsibility and not covered by insurance. Patients who "failed to show" for 2 or more appointments will be discharged without further notification.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Sign: _____ Date: _____
(Patient or legal representative)