

# University City Physical Therapy & *Funtion*SMART Fitness

## FINANCIAL AGREEMENT & CONSENT FORM

### ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to University City Physical Therapy of the benefits otherwise payable to me for services rendered.

### IF MY INSURANCE PAYS ME DIRECTLY

If my insurance or other source reimburses me directly, I will immediately endorse their check over to University City Physical Therapy or submit payment with my own personal check.

### MEDICARE AND CHAMPUS

This office **DOES accept MEDICARE and CHAMPUS** assignment. You agree to pay all co-payments or co-insurance amounts not reimbursed under the medical insurance part of the Medicare Part B Program and or secondary insurance for services rendered. *Patient must see referring physician every 30 days.*

### DEDUCTIBLE/PERCENTAGE & CO-PAYMENTS

Co-payments are to be paid **AT TIME OF SERVICE**, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the end of each month. **Payment is due within 15 days of the date on the invoice.** Patients are to keep payments current.

### CANCELLATION & NO-SHOW POLICY

*I understand that cancellations must be made 24 hours prior to the scheduled time, unless extenuating circumstances prevent otherwise. The fee for no-shows and late cancellations is \$30.00.*

### LEGAL FEES

I agree that should it become necessary for my account to be referred to an attorney or agency for collection or suit, I will pay all reasonable attorney's fees and collection costs.

### SUPPLIES & EQUIPMENT

All supplies and equipment given to patients shall be paid for by the patient upon receipt, **unless this is an accepted Workman's Compensation case in which insurance will pay.**

### CONSENT FOR TREATMENT

I, the undersigned, a patient at UCPT do hereby authorize Gino Cinco, PT, Certified ART, and Kristina Gray, PT, Renee Cinco, PT and whomever they may designate as their assistant to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that physical therapy requires physical contact, and that I can refuse any part of the treatment that makes me feel uncomfortable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that UCPT will prepare insurance forms, and will bill only as a courtesy my insurance company directly. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

By signing below you are agreeing to all the terms and conditions.

\_\_\_\_\_  
Patient or Legal guardian's signature

\_\_\_\_\_  
Date

\*Please note that UCPT will not cooperate with any attempt to file multiple claims for the same loss or injury with more than one insurer with the intent to defraud the insurer. (CA Insurance Code Section 556.1)