



Patient's name (printed) _____

Financial Policy

Patients with insurance coverage; Optimum Physical Therapy Associates, PC will help you obtain information about your physical therapy benefit from your insurance plan and will bill your insurance company. The physical therapy service you have elected to utilize results in a financial responsibility on your part. This responsibility obligates you to ensure full payment of our fees. You are responsible for payment of your bill. We will call your insurance carrier and review the benefits you have selected for physical therapy. Portions of the bill may not be covered by your insurance company and will have to be paid by you. Usually, there is a CO-PAYMENT and/or an annual deductible as per the insurance plan you choose.

I have read the above financial policy regarding my financial responsibility to OPT, for providing physical therapy services to me, or the above named patient. I certify that the information I have provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay OPT the full and entire amount of the bill incurred by me, or the above named patient.

Patient Signature _____ Date _____
(Or of Parent or Legal Guardian)



Patient's name (printed) _____

Consent To Treatment

I have been informed by a physical therapist about the nature and purpose of my physical therapy evaluation, the procedures to be performed, and the proposed course of treatment. I have been informed of the expected benefits of the proposed treatment as well as the probability of their occurrences. I have been informed about the reasonable alternatives to the proposed treatment and the risks and consequences of forgoing treatment. I have had the opportunity to ask and have answered any questions that I have regarding my evaluation and the proposed course of treatment. My signature on this form indicates that I consent to treatment and understand the risks and benefits as they have been explained to me.

Patient Signature _____ Date _____

The above named patient is a minor or otherwise unable to consent on his or her behalf. I represent that I am the parent or legal guardian of the above named patient and have the legal authority to consent to evaluation and treatment.

Parent/Legal Guardian _____ Date _____

No Show/Cancellation Policy

Your therapist reserves specific time for your appointment. We understand that there may be times when you must cancel an appointment, but we require a minimum of 24 hours notice of any cancellation. Any missed or canceled appointment with less than a 24 hour notice may result in a charge of \$25.00 that is not billable to your insurance.

Patient Signature _____ Date _____

(Or of Parent/Legal Guardian)