Consent for Care and Treatment

This is to certify that I, ____ give authorized personnel of Matrix Physical Therapy, LLC permission to provide physical therapy treatment that is considered prudent medical practice for my illness, injury or condition.

Signature of patient (guardian if under 18): ____________________________________

Print Name __________________________________Date__________________________

Billing Policy, Release, and Authorization

I authorize Matrix Physical Therapy, LLC or their representatives (DR Advantage, LLC) to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Matrix Physical Therapy, LLC. I authorize Matrix Physical Therapy or their representatives to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges and agree to pay my coinsurance, copayment, any applicable deductible, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand that I am responsible for knowing and meeting the requirements of my insurance plan, or those mutually agreed upon by myself and Matrix Physical Therapy, LLC, and stated below. I understand that if insurance checks are mailed to me, I must endorse them and make payable to Matrix Physical Therapy, LLC.

Please pay the balance in full at the time of service or upon receipt of monthly statement or notice. In the event that you are unable to pay the balance in full, we will attempt to make reasonable payment arrangements (agreeable to both parties). Please be advised that Matrix Physical Therapy, LLC is not a credit guarantor , and therefore failure to maintain these arrangements could result in the placement of your account with a collection agency (patient will then be responsible for any fees incurred in this event). Credit Cards are an acceptable method of payment. Self Pay patients please initial_____.

I, the patient am responsible to inform Matrix Physical Therapy, LLC of any changes in my insurance status in a timely fashion. Any charges that are not reimbursed due to a change in my insurance without appropriate notification to Matrix Physical Therapy, LLC will be my self-pay responsibility.

Patient Responsibility: ______________________________

Patient Signature: _______________________________ Date: _______________________

Print Name: _______________________________ Matrix Representative Initial: ________

Patient Responsibilities/Cancellation Policies

- Patient must have a valid prescription from physician.

- If patient is more than 15 minutes late to an appointment, Matrix Physical Therapy, LLC has the right to cancel the appointment and charge a $25 cancellation fee. We will make every effort to accommodate the patient, if possible.

- Twenty-four hours notice of a cancellation must be given or a $25 cancellation fee will be charged. To avoid this charge, the appointment may be re-scheduled in the same week (Monday-Friday). If the rescheduled appointment is cancelled, patient will be charged for both appointments ($50).

- If a patient misses 2 consecutive appointments without calling, all future appointments will be cancelled. We are not required to notify patient.

- The cancellation charges stand for all insurances including private insurers, Medicare, No-Fault, Worker's Compensation, or any other insurance company.

- Matrix Physical Therapy, LLC will make every effort to accommodate schedules or unforeseen events within the best of our ability, although it is not always possible.

- I acknowledge that I am responsible for all late cancel and no-show fees. These are NOT covered by insurance plans, and will be paid out of pocket.

- I acknowledge that any applicable outstanding deductible, and co-payments are to be made directly to Matrix Physical Therapy, LLC at the time of the initial visit. All subsequent co-payments and cancellation fees are to be made at the time of each visit.

Signature___________________________________ Date_________________________