NAME _____ DOB _____ DATE _____

FINANCIAL AND CANCELLATION POLICIES

Welcome and thank you for choosing Restore Your Core for your Physical Therapy needs. Our mission is to provide specialized one-on-one physical therapy evaluation and treatment in a compassionate manner to enrich the lives of our patients. We have elected to no longer be a preferred provider for insurance companies due to the challenges associated with accepting insurance in the current healthcare environment. Instead, we provide physical therapy under a "fee at time of service" model. This means that payment is due at the time the services are rendered and we will *not* bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may choose to submit to your insurance company.

Your initial appointment will be billed at a slightly higher rate to include the cost of the initial physical therapy evaluation. The price for the initial evaluation will range between $125-150.00 depending on the complexity of your case, the time spent completing the evaluation, and the time spent on education and treatment. Follow up appointments will be billed at $25.00 per unit of time spent.

•$125-$150.00 for initial evaluation & treatment for 50-75 minutes. Your initial evaluation and treatment time is dependent upon the complexity of your case.

•$100.00 for 50 minute appointments

•$75.00 for 40 minute appointments

•$50.00 for 30 minute appointments

•$25.00 for 15 minute appointments

We accept cash, checks, and credit/debit cards at the time of service. Our fees are based on the services provided and the treatments performed during each appointment. The timely payment of your bill is an essential part of your treatment.

Cancellation Policy

As a courtesy to our Therapists and other patients waiting to be scheduled, **we require a 24-hour notice for cancellations.** This allows others on the waiting list to be seen in a timely fashion. Only emergencies and illnesses are excusable.

Please read below and initial beside each item:

_____I agree to pay for my evaluations and treatments at the time of service by cash, check, and credit/debit card.

_____I understand it is my responsibility to contact my insurance company ahead of time, obtain any pre-authorization that is required, and obtain an estimate of my benefits. I understand that my therapist will provide me with receipts, upon my request, that is my responsibility to submit to my insurance company.

_____I understand I will be billed the **full amount** of the scheduled session if I do not show for my appointment or if I do not cancel within 24 hours of my appointment time.

_____I understand if I miss an appointment or do not cancel within 24 hours of my appointment, I will be billed the full cost of my appointment ***via my credit card which will be kept on file***. I understand it will not be accessed in any way except in the case of no-shows, cancellations, or at your request.

_____I understand that I will be given a reminder call or text 24 hours prior to my appointment. I understand that I cannot hold Restore Your Core accountable if I miss an appointment because I did not receive a reminder call or text as I am responsible for recording my appointments at the time they are scheduled.

_____I understand that Restore Your Core, LLC is not a participating provider with Medicare and that the therapist only provides services that are not covered under Medicare guideline (fitness, prevention, and wellness). I fully understand that I will not be able to submit my receipts to Medicare for reimbursement.

_____ I understand that if I would like to transfer my records I will need to request in writing, and pay a reasonable copying fee if I want copies of my records sent to another doctor or organization. The amount of the fee is dependent on the number of pages that will be copied. I authorize Restore Your Core to include all relevant information, including payment history.

Additional Fees/Please read and initial beside each item:

_____A fee of $25.00 will be charged for any returned check.

_____A fee of $35.00-$50.00 (time dependent) will be charged for any paperwork your insurance requires your therapist to fill out.

I have read and fully understand Restore Your Core Physical Therapy LLC financial and cancellation policies and I agree to be bound by its terms. I fully understand that failing to initial any above bullet points does not excuse me from being bound by the policies outlined in this agreement.

X_____Date_____

Signature of patient/legal guardian

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