Financial Responsibility/Credit Policy

(Important Read Carefully)

In our continuing efforts of improve the efficiency of our financial operations, we wish to explain the management of our delinquent accounts. As the vast majority of our patients are responsible and reliable in reconciling their accounts in a timely fashion, this information may be unnecessary for the most of you. However, it is our responsibility to ensure that all our patients are aware of our financial policies. Accordingly, we ask that you read the following policy statement and indicate your understanding and acceptance of its terms by signing in the space indicated below.

> You are expected to pay for services at the time they are rendered. If you have insurance, your payment portion is due at the time of service. If no payment is made on our account within thirty (30) days of the date of service, a past due statement will be mailed to the home address provided. If payment in full is not received within another thirty (30) days, your account will be placed with a law firm or collection agency for more formal collection efforts. Such a referral of our account may result in litigation if it is deemed necessary, and the individuals indicated below may be held liable for the principal, court costs and any attorney's fees awarded if the matter is placed in judgment. Any unpaid account will be charged interest at the statutory interest rate allowed by law in the state of Oklahoma and late charges of $10.00 per month if not paid in full within sixty (60) days of the date of service.

If you have any questions or concerns regarding this policy, please call our business office at (580)699-5455.

I (We) understand and accept the terms of the above outlined financial policy and will abide by the stated terms.

_____ Date: _____
Signature (Patient) (Printed)

_____ Date: _____
Signature (Spouse, Guardian, Responsible Party) (Printed)

_____J.Rodrick_____ Date: _____
Witness (Office Use) (Printed)

Physical Therapy Consent to Treat

I do voluntarily consent to the treatment that has been recommended by my physician. Further I acknowledge that no guarantees have been made to me regarding the outcome of this treatment, which I have authorized.

I understand that as part of my health and medical care, Fusion Physical Therapy originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as: a basis for planning my care and treatment; a means of communication among the health professionals who contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; a means for a third-party payer to verify that services were billed as actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future.

By Oklahoma law we are required to notify you…. **that the information authorized for release may include records which may indicate the presence of a communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

I hereby assign to Fusion Physical Therapy, all payments for medical all services rendered to me or my dependents. **I understand that I am responsible for payment of my account(s) and that this document does not release me from that obligation.** I understand that I am ultimately responsible for understanding and complying with the requirements of my insurance carrier including but not limited to co-payments, deductibles, precertification/recertifications for services provided, non-covered services/supplies, disputed worker compensation claims, etc., and will be held responsible for portions of my bill not covered by my insurance (including charges associated with canceled or missed appointments. A 24-hour notice is required in the event of cancellation. It is the patient's responsibility, when they call to have an alternative time in mind that will ensure they get the full prescribed number of treatments**. A $15 fee for a no-show or cancellation without proper notice will be imposed and will NOT be covered by insurance, including workers' compensation and will be the sole responsibility of the patient**). **Co-payments and /or deductible payments will be due at the time of service.** I authorize any credit balance to be distributed at the discretion of Fusion Physical Therapy.

I authorize my assignment of benefits to be paid directly to Fusion Physical Therapy. I understand I am financially responsible to Fusion Physical Therapy for services not authorized and/or not covered by the insurance company. I authorize the release of any medical or other information necessary to process claims.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of consent/authorizations.

If you have any specific questions or concerns regarding this policy, please call our office at ***(580) 699-5455***.

I (WE) UNDERSTAND AND ACCEPT THE TERMS OF THE ABOVE-OUTLINED FINANCIAL POLICY AND WILL ABIDE BY THE STATED TERMS.

_____ Date: _____

Signature (Patient) (Printed)

_____ Date: _____

Signature (Spouse, Guardian, Responsible Party) (Printed)

_____J. Rodrick____ Date: _____

Witness (Office Use) (Printed)