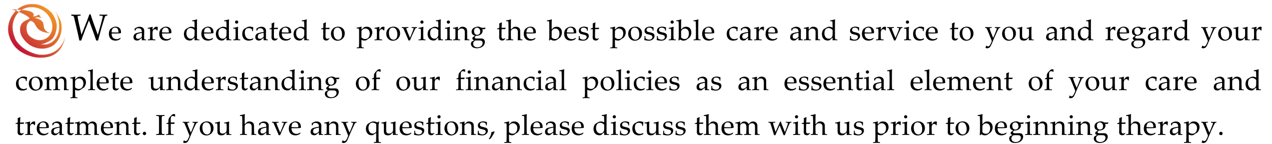
Financial Statement
Consent for Treatment
Cancellation/No Show
Privacy Statement

4498 Main St. @ Harlem Rd., Suite #24
Amherst, NY 14226
p. 716 839-1550
f. 716 839-1696

Patient name: ________________________________



We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with us prior to beginning therapy.

Financial Policy Statement/Assignment of Benefits

By signing you authorize employees and/or agents of Swiatek Physical Therapy PLLC d/b/a Phoenix Physical Therapy to bill your insurance for services received or to bill me as a result of a no show/cancellation of appointment Swiatek Physical Therapy PLLC d/b/a Phoenix Physical Therapy will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The patient/guardian must allow a copy to be stored (physically or electronically) of both sides of the insurance card and identification card (such as a driver's license) to receive treatment under your insurance.

At the time of service, the patient is responsible for any co-payment, deductible or coinsurance identified by the insurer as the patient's responsibility. We will provide you with an estimate of treatment cost for deductible or coinsurance responsibilities. If you have overpaid according to the explanation of benefits provided by your insurance company, we will provide a prompt refund or apply to future payments.

Any payments outstanding after 90 days will be sent to a collections company.

Notice of Advice: We are required to advise you that Physical Therapy treatment may not be covered by your health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner. All proper documentation must be provided at the initial visit, including a doctor's referral if you are receiving treatment under your insurance. *Doctor's referrals are valid for 30 days from written prescription date.* Physical Therapy treatment under "direct access" laws allow for a treatment period of 30 days or 10 treatment visits (the lesser dictating) before notification of and consent by your physician is required to continue treatment.

Cancellation/No Show Policy

A **$30 fee** will be charged to a patient who does not show or who frequently cancels less than 24 hours of scheduled appointment without rescheduling for that same week. This is not covered by your insurance.

Patients who cancel or no show on three separate occasions without good cause will be allowed to schedule additional appointments only at the discretion of the treating therapist.

Consent for Treatment

By signing you give consent for licensed therapists of Swiatek Physical Therapy PLLC d/b/a Phoenix Physical Therapy to furnish physical therapy services that are considered necessary and proper in the treatment your physical condition. It is your right to accept or refuse any treatment offered once information has been given.

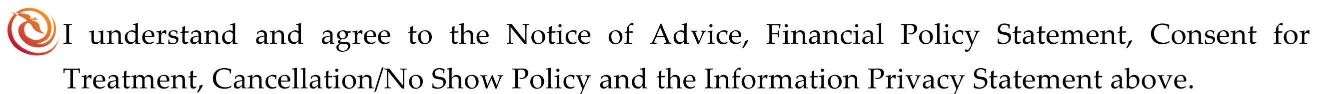
Information Privacy Statement / Notice of Privacy Practice

Swiatek Physical Therapy PLLC d/b/a Phoenix Physical Therapy (employees and/or agents) will use and disclose your personal health information to treat you, to receive payment for the care provided, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care, such as outcome analysis.

I authorize Swiatek Physical Therapy PLLC d/b/a Phoenix Physical Therapy to release any medical or other information necessary to process my claim. I also request payment of government benefits to Phoenix Physical Therapy Services, P.C. who accepts assignment. I authorize the release of information from my medical record, whether it is written, electronic or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in care and payment of medical benefits. I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis. A detailed Notice of Privacy Practices is posted in the Physical Therapy office and you may request a copy at any time.

For improved coordination of care, you may list other individuals that Swiatek Physical Therapy PLLC d/b/a Phoenix Physical Therapy is allowed to communicate with for purposes of coordinating care (i.e. your personal secretary, another medical provider, personal trainer, massage therapist, chiropractor) which may added to or revoked at any time by submitting a request in writing.

___________________________________ ___________________________________



I understand and agree to the Notice of Advice, Financial Policy Statement, Consent for Treatment, Cancellation/No Show Policy and the Information Privacy Statement above.

Patient(Parent/Guardian)____ **Date** ________________

For office use	☐ Insurance Card on file ☐ Patient Identification card on file ☐ Primary Insurance ☐ WC/NF open ☐ Current Prescription ☐ RX NA ☐ other ______________________