Bull City Physical Therapy
(919) 797-9588
pt@bullcitypt.com
bullcitypt.com
1019 Broad Street, Durham, NC 27705
280 Towerview Court, Cary, NC 27513

Consent to Treat and Financial Agreement

Patient Name: ____________________________________

AUTHORIZATION FOR TREATMENT: The client/legal guardian authorizes Bull City Physical Therapy, LLC to administer testing and/or treatment for the patient's diagnosis and rehabilitation. The client/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered. I hereby release the organization and any of its employees from any liability that may be incurred from any loss or damage of valuables and personal items that I have kept in my possession during the treatment session.

PAYMENT AGREEMENT: I agree to be responsible and pay Bull City Physical Therapy, LLC for payment at the time of service for all services rendered on my behalf. Insurance or self payment is due in full at the time of service unless otherwise written agreement is arranged by the client and Bull City Physical Therapy, LLC. Any insurance verification we offer is ***not a guarantee of coverage***. Patients must consult their specific plan policies and customer service representatives.

CLAIMS: I understand that in the event that collection action is undertaken for unpaid claims, all costs associated with collections, including attorney fees, will be incurred by the client/legal guardian.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: I hereby authorize Bull City Physical Therapy, LLC in its discretion, to disclose records and/or medical information to any hospital, physician, or other health care service which may assume continuing patient care or to other persons/organizations in order to obtain and/or maintain licensure, accreditation, or certification to the extent provided by law. I understand that Bull City Physical Therapy, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Signed: ______________________________ Date: ____________

Parent/Legal Guardian: ______________________________

We are committed to you and your healthcare goals. You have a financial responsibility that obligates you to ensure full payment of your bill. All patients must complete and sign the entire patient registration packet before they see the physical therapist. Bull City Physical Therapy, LLC has designed this financial policy to prevent any surprises at the end of the patient's treatment plan.

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Copays/Coinsurance/Deductible: It is our policy to collect co-pays at the time of service. Co-insurances and deductibles will be paid at an estimated fee based on our contract with each individual insurance company, to be paid at the time of visit. Once the claim has been submitted and EOP (Explanation of Payment) has been received from the insurance company will settle up with you. If you have any concerns with payment, please see the owner. A payment plan with a valid credit card number may be required to be on file prior to visit if a payment plan is needed.

Guarantee of Payment: Your healthcare insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct and current information. Your contract dictates the services that are covered and the amount of payment for those services. You are ultimately responsible for payment of services provided. As a courtesy we will verify your insurance eligibility and benefits for physical therapy. However, we strongly advise you to contact your insurance company directly to obtain this information since it is ultimately the patient's responsibility to know and understand their insurance benefits.

Insurance Coverage Changes: If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum visits and obtain referral/authorizations for the visit. It is your responsibility to notify us of ANY insurance changes as they occur (in writing). Otherwise, you may be billed at a private pay rate per treatment visit. See below.

Payment Issues: If financial problems arise, please contact our billing department as soon as possible. If an account becomes past due, necessary action will be taken, up to and including turning the account over to our attorney or collections service. The undersigned understands that he/she or his/her agent is responsible for charges incurred.

Secondary Insurance: As a courtesy, we will bill your secondary insurance, but we require all plan details at the time of service.

Private Pay/Uninsured Options: Evaluation & Following Treatment Session Fee: $149 per visit. Packages are also available reducing the per visit rate to 6 visits = $119/visit and 10 visits = $99/visit. These rates are due in FULL at the time of the each visit. I understand coding for insurance billing is not provided with this billing structure nor will it be able to be added at any time.

Worker's Compensation Claims/Self Insurance Claims: We require prior authorization for all Worker's Compensation claims. You are ultimately responsible for payment or services rendered if your claim is denied. It is your responsibility to provide us with all the information necessary to pursue your claims.

Cancellations: Please call at *least 24 hours beforehand* to reschedule your appointment. If you do not show for your visit or cancel within 24 hours you will be subject to a $100 fee. We value your time and by canceling last minute or no-showing, another patient who is currently suffering from pain may miss their opportunity to see us.

Signed: ______________________________ Date: ______________

Parent/Legal Guardian: ______________________________