



**OFFICE POLICY**

**CONSENT FOR TREATMENT OF A MINOR:** As parent and/or legal guardian, I authorize **Synergy Performance Health & Fitness** treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR CARE & TREATMENT:** Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Synergy Performance Health & Fitness** furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize **Synergy Performance Health & Fitness** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

**WORKERS' COMPENSATION CLAIMS:** If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

**CANCELLATION & NO-SHOW POLICY:** We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is \$50 for physical therapy visits and the full price of a massage or Pilates visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

**FINANCIAL POLICY:** We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit \$ \_\_\_\_\_

Arrangements for payment of patient's co-pay/deductible **(circle one):**

**Will pay each visit**

**Will pay weekly in advance**

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

\_\_\_\_\_  
Patient/Guardian/Responsible Party Date

\_\_\_\_\_  
Clinic Representative Date 10/10/03