PANORAMA
Physical Therapy

Patient Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** ____ **Zip:** _____ **Phone:** _____

Covered Benefits: As a courtesy, we will verify and file your claim with your insurance carrier; however, we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/co-insurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you or your physician elect to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for Physical/Occupational Therapy services.

Co-Payments: Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks, and credit cards (Visa or Master Card).

Attendance Policy: Your therapist allocates a specific amount of time for your appointment in order to meet the needs of your rehabilitation program. We understand that there are times when you must miss an appointment, but request that you give us 24-hour notice. Please schedule a make-up appointment as soon as possible to help meet your rehabilitation goals. So that we may provide attentive care to each of our patients, please be aware that if you arrive more than 15 minutes later than your scheduled time, you may be asked to reschedule your appointment. It is very important for us to have the most current information about your condition. Therefore, if you miss 3 or more consecutive appointments, all future appointments will be cancelled. You will have to contact your physician to receive a new prescription before resuming physical therapy. **Initials** _____

I have read the above statements. It is my understanding that I am financially responsible to Panorama Physical Therapy for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to Panorama Physical Therapy. I agree to pay the full amount of all charges incurred by the above named patient that are not covered by my insurance carrier.

Patient Signature: _____ **Date:** _____

Guarantor's Signature (if patient is a minor): _____

Medical Release: I hereby authorize Panorama Physical Therapy to release my medical records to physicians, insurance companies, and other social agencies as necessary. I also authorize Panorama Physical Therapy to obtain any portion of my medical record from any other institution that is deemed medically necessary in the course of my treatments.

Patient's Initials: _____

Consent to Provide Treatment: I hereby authorize Panorama Physical Therapy through its appropriate personnel to perform upon me, or the above named patient, appropriate assessment and treatment procedures relating to my diagnosis.

Patient's Initials: _____