Thrive Physical Therapy, PLLC. Service and Policy Agreement.

- Please read, initial each section, sign, print name, and date below.

Release of Benefits and Information:

I authorize my insurance benefits to be paid directly to Mari O'Neill Physical Therapy, PLLC (Doing Business As: Thrive Physical Therapy, PLLC). I am responsible for all co-payments, deductibles, and non-covered services as determined by my insurance plan at the time of claims processing. I authorize Mari O'Neill Physical Therapy, PLLC (DBA Thrive Physical Therapy, PLLC) and/or my insurance company to release any information required for this claim. I authorize Mari O'Neill Physical Therapy, PLLC (DBA Thrive Physical Therapy, PLLC) to release any information to referring or consulting health care providers that may be necessary for my care. I consent to receive treatment at Mari O'Neill Physical Therapy, PLLC (DBA Thrive Physical Therapy, PLLC). I certify that a copy or fax of this agreement shall be valid as the original.

_____
Initial.

Missed Appointment/Cancelation Policy:

It is very important for your recovery that you attend all of your scheduled therapy treatments. **We require 24 business hours notice by phone/email if you are unable to keep your appointment.** You will **not** be able to cancel your appointment with online scheduling without a 24 hours notice. By signing below you authorize Thrive Physical Therapy PLLC to charge you a $75 USD for missed appointments with less than 24 hours notice of cancelation.

- If you fail to show for two visits or cancel for two appointments without 24 hours notice, all remaining appointments will be removed from the schedule. If you wish to continue your therapy, future appointments may be limited to day of scheduling.

_____
Initial.

HIPAA privacy policy:

By signing below you agree to the above policies and that you were given an opportunity to review/question the Statement of Privacy Practices. A hard copy of our policy is available at any time upon request. A copy is posted in our facility. Our policy is to protect your privacy. The Statement of Privacy Practices describes the types, uses, and disclosures of your protected heath information that might occur in your treatment, payment for services, or in the performance of office heath care operations including coordinating/facilitating your care with another health care provider. The Statement of Privacy Practices also describes your rights and the responsibilities and duties of this office with respect to your protected health information. You may request in writing to not release information. If you request restriction on payment for services you will be responsible for your account balance and you can bill your insurance company independently.

_____ _____ _____

Signature Print Name Date

Co-pay and/or Co-insurance Policy:

Co-pays are collected at the time of service in form of either cash or check. Thrive Physical Therapy is not currently accepting credit cards. Please come prepared to pay in full. Co-insurance will be billed to you at a later date to insure accuracy with your insurance company.

_____
Initial.

(**OFFICE USE ONLY**:
Co-pay $ _____USD Co-insurance $_____USD)

Insurance Waiver

We will be happy to bill your insurance carrier(s) for your services. After your insurance processes your claims, you will receive a bill for the patient responsibility, which includes deductibles and co-insurance. You will receive a bill if any of the following occurs:

- Treatment is not covered or deemed medically necessary by your insurance plan.
- Your insurance benefits for these services have been exhausted
- Your insurance is pending and not guaranteed to be in effect at the time of service.
- Your insurance will not pay due to the nature or case of your injury
- Pre-authorization was not obtained.
- You failed to make your appointment or did not cancel with >24 hours notice.

Your portion of the bill is due within 10 days of receipt of your billing statement. Rebilling fee of 1% per month is added to account balances over 60 days. If your account is 60 past due, we require that you set up a payment plan. If no payment is made, we reserve the right to discontinue services and a collection call will be made.

In the event of default of payment or failure to pay, you agree to pay all costs of collection including court costs and reasonable attorney fees to be determined by a court of law. If suit is commenced to enforce the terms of this Agreement, the Courts of the State of Washington and federal courts located in State of Washington shall have personal jurisdiction over the patient, and the venue of suit, at the option of Thrive Physical Therapy, PLLC may be laid in the King County, Washington.

By signing below, you agree that you understand and accept the financial responsibility for services. I certify that a copy or fax of this agreement shall be valid as the original.

_____	_____	_____
Patient Signature	Print Name	Date