Please print this agreement. Read over it. And sign confirming your understanding.

SCOTT HOLLIER, INC.
PHYSICAL THERAPY

Dear New Patient,

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our policies and procedures, which we require you to read and sign prior to any treatment.

Medical Information and Treatment

Authorization for treatment and release of medical information

To assist us in your treatment, occasionally we will ask the referring doctor to provide us with medical records. After your initial evaluation, we send the referring physician a summary of our findings, treatment plan and goals that you and the therapist have set. To exchange this information we must have your permission. Legally in order for us to treat you, we must have your written permission.

Authorization is hereby given to release medical information and/or copies of medical records from my physician for any and all of my related previous medical conditions to Scott Hollier, Inc. Physical Therapy.

I hereby authorize Scott Hollier, Inc. Physical Therapy to provide written and/or verbal reports to my insurance company, worker compensation company, and /or my attorneys that I have provided to you as part of my intake information.

I hereby authorize and give consent to Scott Hollier, Inc. Physical Therapy to provide treatment prescribed by my physician related to my rehabilitation.

_____ _____

Signature Date

SCOTT HOLLIER, INC.
PHYSICAL THERAPY

Our Financial Policy

All patients must complete our information, authorization, and insurance form.
FULL PAYMENT OF CO-INSURANCE OR CO-PAY IS DUE AT THE TIME OF SERVICE.
Terms: Patient is responsible for uncollected portion of the bill as well as any attorney fees or collection costs encountered in collection. Terms: Net 30 days. Accounts over 30 days, 1.5% service charge per month, annual percentage rate of 18%.

Regarding Insurance

As a courtesy to you, we will file your claims to the insurance company according to the information provided. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. If, after 45 days, you have not received an explanation of benefits from your insurance company, please contact our office so that we can resolve the problem and the claim can be processed. If your insurance company has not paid your balance in full within 45 days, you are responsible for the full amount. Prior to your visit, our office staff will attempt to contact your insurance company, verify benefits and determine what your financial responsibility will be. Upon arriving for your initial visit, we will review our findings with you and discuss how our billing process works. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under all contractive care and/or other medical information. Should a problem arise, we will try to assist you in any way possible. All deductibles, co-pays or co-insurances are due upon each treatment day.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You will be responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will not be responsible for a discount given due to a contract between your insurance company and us.

Minor Patients

An adult must accompany any and all minors wishing to receive treatment for his/her initial visit. At that time our office staff will coordinate with the parent or guardian of the minor for any future treatment that the minor will receive. The adult or guardian will be responsible for all charges in our clinic.

SCOTT HOLLIER, INC.
PHYSICAL THERAPY

Letter of Guarantee

If we have accepted a letter of guarantee from your attorney or insurance company, we will wait for payment until the time of settlement disbursement. In the event a settlement is not obtained, or if in the event the settlement is less than the bill, you will be responsible for all charges in our clinic.

_____ _____
Print name Social Security Number

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Responsible Party Date
(If different from patient)