Notice of Privacy Practices and Medical Authorization

1. I authorize the release of medical information required in the processing of applications for financial coverage for services rendered while under the care of La Plata Physical Therapy.

2. I authorize direct payment of medical benefits on my behalf to La Plata Physical Therapy. I understand that I am personally responsible for charges not covered by this assignment at the time of treatment, such as copay and deductible charges. This assignment shall be in affect while under the care of La Plata Physical Therapy.

3. Copays and payments are due at the time of service.

4. If your insurance is a plan with a coinsurance, we will collect payment as follows:

5% - 10% coinsurance	$15.00 payment each visit
15% - 20%	$20.00 payment each visit
25% - 30%	$25.00 payment each visit
40% or more	$30.00 payment each visit

5. I understand that it is my responsibility to present a written referral from my primary care doctor if required. If my insurance company denies my claim because I did not bring in a referral from my PCP, I accept full responsibility of paying the charges in which occurred.

6. La Plata Physical Therapy does not accept payment through any attorney

7. La Plata Physical Therapy accepts auto accident cases of any kind on a SELF-PAY BASIS ONLY. Charges are: $150.00 for Initial Evaluation, $75.00 for each visit after. Payment is due at time of treatment and CAN NOT be billed. The patient will be required to submit receipts to auto insurance for reimbursement.

8. I understand there is a $50.00 charge for ANY appointments that are cancelled or broken without a 24 hour notice. This INCLUDES rescheduling of appointments if 24 hour notice has not been given. No exceptions will be made to this policy.

9. I understand that I am responsible for any collection fees incurred if my account becomes delinquent and authorize La Plata Physical Therapy to contact me via phone numbers provided for any billing or financial matters.

_____ _____

Signature **Date**