

Diamond Physical Therapy

1406 E. Algonquin Rd.

Algonquin, IL 60102

(847) 854-0196 Fax (847) 854-0197

I hereby give permission for, _____, to be treated by Diamond Physical Therapy for therapy services. Therapy services have been explained to me, I understand this treatment and explanation and approve of said treatment.

The policy of this clinic is that payment is due at the time of service. Insured patients are expected to take care of their fees as services are rendered. Your clear understanding of our financial policy is important to our relationship. Your assistance in complying with our payment policies will help control our overhead expenses, thereby keeping fees reasonable.

Patients who carry health care insurance should remember that professional services are rendered to and charged to the patient and not to the insurance company. When we file a claim for you, you will receive a statement each month if your account has a balance due. Please understand that the insurance carrier may pay less than the actual bill for services. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed benefit/claim. You are responsible for payment of your account within the limits of our office credit policy.

If, for any reason, your account is referred to our collection agency, you will be responsible for all collection costs, court costs and reasonable attorney's fees.

If a carrier should deny coverage, you will be responsible for the account. Failure to keep your account current may result in Diamond Physical Therapy being unable to provide additional services. Credit may be extended upon request in cases of sizable balances. We accept cash and checks.

If your insurance card has not been issued to you by the time of your visit, you will be treated as a self-paying patient; payment will thus be expected at the time of the visit and the claim will be submitted for you when we receive a card. Please be sure to notify our office immediately should you change medical insurance carriers, home address or telephone number.

As a client of Diamond Physical Therapy your signature is required below as acceptance of our office policies and as acknowledgement that you have been advised of these policies. In addition, your signature will service as authorization to release medical account information to your insurance carrier(s) to process your medical claims, as needed.

Your signature also denotes that you recognize and accept full responsibility for all professional services rendered and further authorizes the insurance carrier(s) to pay benefits directly to this clinic if a balance is due.

It is our policy that the parent or guardian accompanying the child to the clinic will be responsible for full payment of the bill. Thank you for you understanding. Please let us know if you have any questions or concerns.

Signature of Patient

Date

Signature of Parent/Guardian

Date

Witness

Date