myPT
raise your expectations

Financial Policy Agreement

Available Payment Forms

Cash; Check made payable to myPT

Payment Policy

Payment is due in full upon receipt of an invoice from myPT. This includes privately paying clients, co-payments and share-of-cost, co-insurance or deductible fees. It is your responsibility to be aware of your insurance coverage and any co-payments, fees associated with the treatment you are receiving from myPT. You will be given a receipt to verify your payment.

Cancellation/Missed Appointment Policy

Your appointment time is reserved for you, and your insurance company does not pay for missed or late-cancelled appointment.

24 hour notice is required for cancellations of scheduled appointments. If you have an emergency situation or become ill, please contact myPT by 8am on the day of your scheduled appointment to notify and explain the cancellation.

If there are chronically missed or cancelled appointments, you may lose your standing appointment spot.

Returned Check Policy

There is a $25.00 charge for each check returned to myPT by the bank.

Insurance Coverage Policy

Your insurance coverage is a contract between you and your insurance coverage. You are responsible to understand your policy and for all co-payments, deductibles, co-insurance and any other fees related to services you receive from myPT. You are responsible for knowing if your insurance company requires prior authorization for services received via myPT.

It is your responsibility to inform myPT of any changes to your insurance type, insurance plan, primary physician or physician's group, all of which could affect your coverage for PT services. If myPT is not informed, you may be responsible for the cost of the services rendered after these changes occur.

I understand and agree to abide by all the conditions and obligations described above and my signature affirms that I agree to enter into this service contract with myPT to provide physical therapy services. I understand my payment of $_____ per visit is due at the time services are provided. I further declare that I have verified that my insurance provider has approved the balance of the incurred fees for payment. If my insurance provider should not make payment for the balance due, I agree to be responsible for the unpaid balance.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you or your child, as a patient of myPT, may be used and disclosed, and how you can get access to your (child's) health information. This is required by the Privacy Regulations created as a result of the Health Portability and Accountability Act of 1996 (HIPPA). Please read the following, sign below and return to us. HIPPA requires this is order for us to have you (your child) as a patient.

Our commitment to your privacy

myPT is dedicated to maintaining the privacy of health information. We are required by law to maintain the confidentiality of this health information. We realize these laws are complicated, but we must provide you with the following information:

Use and disclosure of health information in certain special circumstances

The following circumstances may require use to use or disclose you or your child's health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order if required to do so by a law enforcement official.
3. If requested to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your (child's) health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organizations able to help prevent the threat.
5. If you are a member of the US military forces (including veterans) and if required by the appropriate officials.
6. To federal authorities for intelligence and national security activities' authorized by law.
7. To correctional institutions or law enforcement officials if you or your child are an inmate under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your (child's) health information:

1. Communications. You can request that myPT communicate with you about your (child's) health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. myPT will accommodate reasonable requests.
2. You can request a restriction in the use of our disclosure of your (child's) health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of health information to only certain individuals involved in your (child's) care, such as family members and friends we are not required to agree to your request, however, if we do agree, we are bond by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you (your child).
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your (child's), including psychotherapy notes. You must submit your request in writing.
4. You may ask us to amend your (child's) health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for the amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with myPT or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. myPT will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If a disclosure of your (child's) protected health information was made for a reason other than treatment, payment or healthcare operations, you have a right to receive an accounting of this disclosure.

Please let us know if you have any questions regarding this notice or our health information privacy policies.

I hereby acknowledge that I have been presented with a copy of myPT's Notice of Privacy Practices.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

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CONSENT TO RELEASE CLIENT INFORMATION

I authorize myPT to obtain client information from and release client information to, only the professional agencies and/or individuals listed below:

_____
Patient Name

_____
Date of Birth

NOTE: Written reports and updated progress reports will be automatically sent to the funding agency. You grant myPT permission to forward these reports to these funding agencies when you affix your signature below.

I understand that all information help by myPT is strictly confidential.

NAME	ADDRESS	PHONE

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

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PERMISSION TO REPRODUCE PHOTOGRAPHY
(Optional)

By signing my signature below, I give my permission for myPT to use and reproduce photographs/videos of:

me, my son, my daughter, my family and/or my caregivers.

For use in:

- □ Documentation related to provided services.
- □ *my*PT's website and/or promotional materials
- □ Materials intended for educational purposes

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

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Waiver of Liability

While *my*PT makes every effort to ensure the safety of all clients at all times, *my*PT cannot accept responsibility for the supervision and/or safety of other family members and caregivers during PT sessions.

Furthermore, since *my*PT helps integrate PT services into your life by offering services in your home and community environments, the safety of those environments are beyond the control of *my*PT. Therefore, the company cannot assume any liability for the physical surroundings and conditions in which the services are provided.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

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APPOINTMENT DURATION POLICY

A clinical hour includes: direct client therapy, contact with other professionals regarding you (your child) and consultation with you about your (child's) progress, goals and treatment plan. Appointments are generally conducted as follows:

APPOINTMENT	DIRECT THERAPY	CONSULATION/DOCUMENTATION
1 HOUR	50 MINUTES	10 MINUTES

I understand and agree with the appointment duration policy stated above.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY SEX M F				4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other				7. INSURED'S ADDRESS (No., Street)
CITY		STATE	8. PATIENT STATUS Single Married Other				CITY STATE
ZIP CODE	TELEPHONE (Include Area Code)		Employed Full-Time Student Part-Time Student				ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) YES NO				a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F			b. AUTO ACCIDENT? PLACE (State) YES NO				b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? YES NO				c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a 17b NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE 7/15/13	a b	a b