

Consent/Financial Policy

1. Consent for treatment: I agree to medical treatment by Cornerstone Physical Therapy Associate, LLC, its employees and independent practitioners.
2. Personal Belongings: I understand that Cornerstone Physical Therapy Associates, LLC is not responsible for any personal property or belongings I may have while I am at therapy.
3. Insurance billing: We will be happy to bill most insurance companies if you provide our office with all the necessary information. For identification and billing purposes it is our policy to require patients to provide their social security number. Your co-payment or co-insurance is due at the time of your visit. If you have no insurance, payment in full is expected at the time of your visit. We accept cash, checks, Mastercard and Visa.

We participate with: Harvard Pilgrim Healthcare, Anthem, Blue Cross Blue Shield, MVP New Hampshire, Aetna, Cigna, Medicare, Medicaid, United Healthcare, Tricare, and Workmen's compensation.

For insurances that we do not participate with, we will make reasonable effort to bill. However, there may be limited benefits or no benefits for services. Please be advised that it is your responsibility to contact your insurance company to check your plan coverage before coming to our office.

4. Managed care insurances: For all HMO's, please be advised that it is your responsibility to make certain that a referral authorization has been received in our office prior to your appointment or bring your referral with you at the time of the appointment. The exception to this would be a PPO which allows you to choose treatment without referrals.
5. Workman's Compensation: We will be treating you for your work related injury only during your scheduled appointment. If you have another problem that you wish to be seen for, we ask that you make a separate appointment.

Re-injury: If you have a re-injury to a previous claim, your employer must be notified and our office provided with the new claim number, if one is issued. Otherwise, if your claim is denied as unrelated, you will be responsible for all services until your claim is straightened out.

Denied claims: We require that you provide our office with your health insurance information at the time of your first appointment in the event that your workers' compensation claim becomes denied. Our office policy is to bill your health insurance and you will be responsible for any remaining balance.

6. Additional Information: If your insurance company requires that you provide them with a signed claim form or accident details, it is your responsibility to do so. Failure to respond to requests from your insurance company will result in the balance becoming your responsibility.
7. Release of Medical Information
I authorize Cornerstone Physical Therapy Associates, LLC to release my medical information to my insurance company, HMO, or other third party payors, as

necessary to bill and receive payment for my physical therapy. I hereby assign to Cornerstone Physical Therapy Associates, LLC. all payments for medical services rendered.

7. Assignment of Benefits:

If I have health insurance or worker's compensation, I authorize Cornerstone Physical Therapy Associates, LLC to bill these companies directly and I authorize the insurance companies to make payment directly to Cornerstone.

Non-Coverage charges: I understand that my insurance may pay all or, some or none of my physical therapy services. I agree to pay all charges that are not covered by my insurance, including services where I fail to obtain proper physician referral/authorization. I understand that if I do not make prompt payment for these charges, I will be responsible for any collections costs, including the payment of attorney fees.

Patient Signature _____ Date/Time _____

Patient name Printed _____

Parent Signature(if minor) _____ Date/Time _____