

**REMOBILITY PHYSICAL THERAPY**  
**3901 Roswell Rd Ste 100A, Marietta GA 30062-8811**  
**Tel: 770-578-4343, Fax: 770-578-4342**  
**www.remobility.com**

## **TREATMENT & FINANCIAL POLICIES**

Welcome to Remobility! We are glad that you have chosen us for your physical therapy and wellness needs. Please read each section thoroughly and initial beside it if you understand and consent. If you have any questions, please speak with our staff.

### **CONSENT FOR TREATMENT**

I, the undersigned, authorize Roël Fung-A-Wing, PT, or a qualified substitute to administer evaluation and treatment as is necessary. I attest that I am not currently under the care of a Home Health Agency; if I should receive Agency care, including nursing services, I will immediately notify Remobility Physical Therapy. I understand that no guarantee has been made as to the results of therapy, which may include modalities, exercise, manual techniques or certain functional activities. I understand that there are some risks and benefits of said treatment, that I have the right to ask questions about any procedure and that I may refuse treatment at any time.

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INITIALS

### **MISSED APPOINTMENTS**

Office hours are by appointment, Monday – Friday, 8:00am – 5:00pm. Remobility does adapt this schedule from time to time according to patient needs, holidays or unforeseen occurrences. We respect your time and will make every effort to see you as promptly as possible.

CANCELLATIONS: I understand that if I must cancel an appointment, I should give 24 hours notice as a courtesy to the patients and staff of Remobility. If I am unable to attend a scheduled appointment, **I will notify Remobility Physical Therapy a minimum of 4 hours in advance. Without such notice, I agree to pay a \$30 non-cancellation fee prior to beginning my next visit.** I understand that this charge is not billable to my insurance company.

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INITIALS

### **PAYMENT FOR SERVICES**

Remobility's fees are based on industry standards in the metro Atlanta area. We accept cash, personal checks drawn on Georgia accounts, money orders, Visa, MasterCard, and Discover. If you have insurance, we will gladly submit claims on your behalf, however co-payments, co-insurance, and deductible amounts will be collected at the time of service. You will be billed for any balances owed after claims have been processed by your insurance company. Unless prior arrangements have been discussed, all payments will be due at the time of service.

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INITIALS

### **ASSIGNMENT OF INSURANCE OR OTHER BENEFITS**

I understand that physical therapy treatment, if covered by my insurance plan, may require a written order/prescription from my physician or surgeon or an advance authorization from my insurance company. I further understand that if a referral or pre-authorization is required, then this must be submitted to Remobility before I begin

treatment, otherwise, the visit(s) may not be reimbursed by my insurance company and therefore I must pay for unauthorized visits in full at the time of service.

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INITIALS

I certify that the information I have provided Remobility Physical Therapy for payment of services is correct. I understand that my insurance plan is a contract between me and my insurance company, and therefore I am ultimately responsible for the cost of my treatment with Remobility. I hereby give authorization to this clinic to submit claims to insurance or other third party on my behalf, as well as seek payment for provided services. I authorize Remobility to assign my insurance benefits to this clinic and deposit such payments to satisfy my account balance for services rendered.

If my insurance coverage changes, it is my responsibility to inform the clinic immediately. I agree to pay my share of my financial obligation in a current manner. I realize that I am responsible for all charges billed, including those not paid by said insurance company. I am also responsible for any interest, collection, attorney, or legal fees incurred to collect payment for services rendered.

**PRIVACY OF INFORMATION**

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INITIALS

I understand that certain information about my care may be shared by Remobility Physical Therapy with insurance companies, attorneys, or employers. I authorize Remobility Physical Therapy to release such information as is necessary. I authorize Remobility Physical Therapy to keep a photo of me in my medical records for identification purposes. I also authorize my therapist to photograph me for my therapeutic record. These photos may be shared with insurance carriers or attorneys when requested, to ensure payment and/or for educational purposes. I have been made aware of my rights under the federal privacy act and that Remobility Physical Therapy will make every effort to protect those rights.

I have thoroughly read and agree to the above policies.

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Print name of Patient and/or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature