CRAY PHYSICAL THERAPY & ASSOCIATES PATIENT AGREEMENT

The following are our office policies. ***Please read carefully*** *before signing, and be sure to ask questions you might have prior to signing this document.*

As a condition of my treatment by Cray Physical Therapy & Associates ("Cray PT") I _____ (Please print name) agree to the following:

1) I am responsible for understanding my own insurance coverage. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as required to qualify my treatment for coverage. I agree to inform Cray PT of any changes to my insurance.
2) If Cray PT does not receive insurance authorization for my treatment, I understand that I may sign an insurance waiver, which is valid for one treatment session.
3) I agree to pay any received co-payment at every visit, or in advance.
4) I will pay for any non-covered medical supplies (ie. Theratubing, Ionto pads) at the time of the disbursement.
5) We request a 24 hour notice in the event of cancellation. I understand that I will be charged a $35 fee for any missed appointments or appointments cancelled without 24 hours-notice. I understand that treatment might be terminated if I cancel or no-show for 3 appointments without rescheduling. *We only treat patients who help us get them well.*
6) If my check is returned to Cray PT for insufficient funds, I agree to pay applied bank charges in addition to the amount of the check.

Consent to Treat/Informed Consent

7) I authorize Cray PT to evaluate and treat my injury and perform any therapeutic procedure or treatment that is consistent with my diagnosis. I authorize Cray PT (including students in training) to administer treatment under the direction and supervision of the physical therapist. I will be given the opportunity to ask questions regarding my treatment, if they so arise, and that my physical therapist will be available to answer my questions. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks and my condition may worsen on rare occasions. No guarantee or promise has been made to me concerning the results of treatment. I understand that I can terminate any treatment at any time if I so desire.

Payment Guarantee

8) In consideration of the services rendered and to be rendered by Cray PT, I expressly guarantee payment of my account and agree to pay any charges left unpaid in whole or in part by my insurance carrier, and that I am ultimately responsible for account totals and balance regardless of the disposition of the insurance carrier.

Assignment of Benefits

9) I authorized payment directly to Cray Physical Therapy & Associates for services rendered.

_____ _____

Signature of Patient/Parent/Legal Guardian Date