Action Potential
One on One Physical Therapy

Client Name: _____ DOB: _____

Statement of Patient Financial Responsibility

Action Potential, LLC, is pleased to be your specialized physical therapy provider. The services you have elected to receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your primary insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill. You are responsible to notify Action Potential, LLC of any changes to your insurance plan.
You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. These payments are due at the time of service. You are also responsible for any amount not covered by your insurance carrier. If your insurance carrier (including Workers Compensation and Motor Vehicle) denies any part of your claim, or if you elect to continue services past your approved period, you will be responsible for your balance in full.
I have read the above policy regarding my financial responsibility to Action Potential, LLC and I authorize my insurer to pay the full and entire amount of the bill for the above-mentioned patient. I will assume responsibility for any remaining balance.

_____ **(initial) Your co-payment amount:** _____

Office Policies

_____**(initial)** There will be a **$25.00** penalty assessed for any returned check.

_____**(initial)** We request 24 business hours notice for all cancellations due to our one to one policy. Cancellations made in less than requested time allotment will result in a **$50.00** charge.

Consent to Treatment

_____**(initial)** I hereby consent to evaluation and treatment by the therapists at Action Potential, LLC.

_____**(initial)** I consent that messages may be left on my voicemail regarding scheduling and my plan of care.

_____**(initial)** I consent to being photographed or video taped for the purpose of patient education, instruction, and development of a home exercise program. I am aware that media specific to my plan of care will be placed in my medical record as protected health information and only disclosed to me. Media will not be disclosed further without my consent.

_____**(initial)** I give my permission and would like to be contacted about continued after care programs.

Client Signature: _____ **Date:** _____

Client Representative: _____ **Date:** _____
(If patient is a minor, or if authorized by patient)