Physical Therapy
& Sports Rehabilitation

POLICIES

We, at Agility Physical Therapy and Sports Rehabilitation, LLC, are dedicated to providing the best possible care and services to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office manager and/ or your therapist.

Health Insurance

We are contracted with most insurance plans to accept assignments of benefits. Our office will file your visit with the insurance company and will only collect your co-pay, deductible, and / or coinsurance when it applies. The copay and co-insurance will be collected at each visit along with a portion of the deductible, if applicable. If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from this office.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFO TO THE APPROPRIATE AGENCIES AND REQUEST THAT BENEFITS BE PAID DIRECTLY TO AGILITY FOR SERVICES RENDERED. I UNDERSTAND THAT AGILITY IS FILING MY CLAIM AS A COURTESY AND THAT THIS DOES NOT RELIEVE ME OF FINANCIAL RESPONSIBILITY OF NON-COVERED SERVICES OF SUPPLIES.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES THAT I RECEIVE. PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGMENTS HAVE BEEN MADE. I UNDERSTAND THAT THERE WILL BE A $30.00 NSF FEE FOR ANY RETURNED CHECKS.

Referrals

It is your responsibility to obtain a valid referral from a physician, nurse practitioner, chiropractor or physician assistant in order to be treated in physical therapy, unless it is through direct access.

Appointment Time / No Show / Cancellation Policy

Our office will make every attempt to confirm your initial scheduled appointment, but it is ultimately your responsibility to cancel or reschedule when necessary. If you are late for your appointment, your time may be shortened or rescheduled to minimize disruption to the other clients. Our office reserves the right to charge a $25.00 fee for failure to inform our office of appointment cancellation or no show.

Acknowledgement Of Receipt Of Notice Of Privacy Practice

I ACKNOWLEDGE THAT THE NOTICE PRIVACY PRACTICES WAS AVAILABLE AMD THAT I HAVE READ (OR HAD THE OPPURTINITY TO READ IF I CHOOSE) AND UNDERDTAND THE NOTICE.

11450 Space Center Blvd, Suite 201
Houston, TX 77059

306 W. Edgewood Drive, Suite E
Friendswood ,TX 77546

Ph: 281-998-0901 Fax: 281-998-0903

http://agilityphysicaltherapy.net

Authorization to Release Information to Individuals Involved in Patient's Care

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information.

I authorize Agility Physical Therapy to disclose my health information that is directly related to my current treatment at Agility to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received. Your information will only be given to you, your referring doctor, your insurance company, and the responsible party unless otherwise stated.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

Name:_____ Relationship:_____

_____ _____

Consent of Treatment

I hereby authorize Agility Physical Therapy through its appropriate personnel, to furnish medical care and treatment to me, or the above-named patient's, considered necessary and proper in diagnosing or treating my/ his/ her physical condition.

Appointment Reminders

I would like to receive appointment reminders by email. **Yes or No**

I would like to receive a billing statement by email upon completion of therapy. **Yes or No**

_____ _____

Email address **Date**

Emergency Contact

Name: _____

Relation: _____ Phone: _____

Please sign to agreement

I have read and understand the office policies, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature (Patient or Responsible Party) **Date**

_____ _____

Print Name (Patient or Responsible Party) **Patient's Name (if not responsible party)**

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