PAYMENT/BILLING POLICIES AND RELEASE FORM

Thank you for choosing our facility for your physical therapy needs. The following information concerning our payment and billing policies should prove helpful in answering any questions you might have.

NO INSURANCE COVERAGE: Payment is expected at the time of service, Unless prior arrangements are made.

AUTOMOBILE ACCIDENTS: As a courtesy to you we will bill your insurance company for you. You will be billed for any non covered portion as we receive payments or explanation of benefits from your insurance company. Payment is due within 10 days of receipt of our statement to you. **Insurance companies will not pay us for a third party auto accident. Payment will be expected at the time of service.**

NON CONTRACTED INSURANCE: As a courtesy to you we will bill your insurance company for you. You will be billed for any non covered portion as we receive payments or explanation of benefits from your insurance company. Payment is due within 10 days of receipt of our statement to you.

CONTRACTED INSURANCE: If you are covered by an insurance plan in which we are a contracted provider, your co-payment (if applicable) is due at the time of each service. Any deductibles or non covered services which are the patients responsibility per our Contract will be billed as we receive payments or explanation of benefits from your insurance company. Payment is due within 10 days of receipt of our statement to you.

MEDICARE: We accept Medicare assignment. Medicare will send payment directly to us. If you have a secondary insurance company, please be sure to provide us with this information . Medicare will pay 80% of approved charges. In most cases your secondary insurance will cover the 20% of approved charges. You will be responsible to pay for any of the 20% that your secondary insurance does not cover**.**

NO SHOW/CANCELLATION POLICY: When you make an appointment, time will be exclusively reserved for you to insure quality time for treatment. If you need to cancel an appointment please give at least 24 hours notice. A **$40.00** fee will be charged for failure to give 24 hrs notice.

If you need further explanation of any of the above policies please feel free to ask receptionist or call our billing office at (503) 982-8544.

******** WAIVER OF ANY OR ALL OF THE ABOVE PROVISIONS DOES NOT CONSTITUTE A PERMANENT WAIVER OF SAID PROVISIONS *********

ASSIGNMENT OF BENEFITS

As a patient or legal guardian, I agree to pay for all services rendered in accordance with the terms and conditions set forth in this policy. I authorize the release of any medical information necessary to process insurance claims. **Assignment of benefits:** if applicable, I authorize insurance benefits to be paid directly to **: David Marquis, DPT, Marquis Physical Therapy & Spine Rehab, P.C..**

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Signature of Patient or Legal Guardian **Date**

CONSENT TO TREATMENT

I have been informed by **David Marquis, DPT** of the treatment and care which has been prescribed by my physician(s) and will be provided by **David Marquis, DPT.** I understand as a patient, I am under the care and control of my physician(s) and that **David Marquis, DPT** is not liable for any act or omission when providing treatment in accordance with my physician's prescription. I acknowledge that no guarantee or assurance has been, nor can be made by David Marquis, DPT as to the results of the prescribed treatment. By signing this agreement, I consent to have David Marquis, DPT provide the treatment and care prescribed by my physician. I understand this consent may be revoked by me at any time.

Date_____ **Signed**_____

signature of client/spouse/parent/conservator/guardian/clients representative

_____ _____

Witness **Relationship**