

CLIENT SERVICE AGREEMENT

Name: _____

SSN: _____

- We are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.
- **INSURANCE** Back to Normal Physical Therapy (BTN) strives to provide the highest quality patient care. As health care costs continue to rise, BTN makes every effort to maintain our standards of care. In order to honor this commitment, we are an out-of-network provider. Please be advised that we will not file insurance claims. As a courtesy to you, BTN will provide you with an invoice for all services rendered. You are responsible for paying at time of service and at your discretion can submit for reimbursement to your insurance company.
- **PAYMENT** - All payments are due at the time services are rendered. We accept cash and personal checks. Returned checks are subject to a service charge of \$25.00 or 5% of the face value, whichever is greater. Accounts not paid in full may accrue interest at the maximum rate allowed by law. In addition to the previous interest BTN may charge a processing fee of \$25.00 per month if your account is late or delinquent. In the case of default on payment you agree to pay any reasonable collection or attorney fees.
- **RETURNED CHECKS** – By signing this form, you authorize BTN to initiate a debit entry to your checking account at your bank for the amount rendered on such returned check and an additional debit entry for \$30.00 or legal maximum, whichever is less, if the item is dishonored. This authorization will remain in force until such time that a written notification, addressed to us, and signed by you or your legal representative is received.
- **APPOINTMENTS** – Office hours are by appointment only, call the office to schedule your appointments. To set up your first appointment please contact us at 727-698-1662 or backtonormalpt@me.com. To set up an individual follow up appointment, please visit our online reservation system at <http://clients.mindbodyonline.com/ws.asp?studioid=12376&stype=-9>
- **CANCELLATIONS** - At the discretion of BTN, late-cancels and no-shows may incur a charge that represents the full cost of your scheduled session. To prevent missed appointment charges patients must call 24 Hours prior to their appointment to cancel the appointment. Patients who do not cancel appointments, may be discharged from the practice after 3 missed appointments.
- **MULTIPLE VISITS** – Multiple visits are situations when a caregiver, parent or spouse attends therapy session of one client but request a consult regarding a person other than the present client. These requests may be treated as a separate service with the corresponding fee.
- **COUNSELING/NEXT OF KIN SESSIONS** – Due to limited space only one person is authorized to accompany the patient. Additional sessions may be scheduled with the patient’s authorization to explain the condition and treatment to relatives or a guardian. This is a separate visit and will be billed accordingly.
- **FORMS** – Patients requiring any type of form or paperwork to be filled must schedule an appointment with the provider. Specific forms must be provided by the patient and presented at the time of the visit. BTN reserves the right to charge for faxes, copies, and filling of forms. Preparation, set up and copies of the medical record will result in a charge of \$17.00. Patients interested in accessing their records on line will be charged a license fee as dictated by Back to Normal’s IT agreement with Associate.
- **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)** –Your signature in this document acknowledges receipt of our present Notice of Privacy Practices and understanding of the same. Copies of the Notice of Privacy Practice may be obtained by visiting our web site. Furthermore, your signature also authorizes BTN to use and disclose protected health information (PHI), including but not limited to HIV/Aids, Psychiatric and Substance Abuse, to carry out treatment, payment, and healthcare operations (TPO) and authorizes BTN and/or its appointed representatives to call your home or other alternative location and leave a message on voice mail or in person in reference to any items that assist BTN in carrying out TPO. BTN may also mail to your home or other alternative location any items that assist them in carrying out TPO.
- **ON LINE COMMUNICATIONS CONSENT**- I acknowledge that I have read and fully understand BTN’s On line Communication Consent form. I understand the risks associated with the communication of online communications and consent to the conditions outlined. In addition, I agree to the instructions outlined as well as any other instructions that BTN may impose to communicate via online communications. I have had a chance to ask any questions that I had and to receive answers.
- **BILLING ERRORS AND QUESTIONS** – If you think your bill is wrong, or if you need more information about a transaction on your account, write us on a separate sheet at the address listed on your bill. Items on the bill that are not in dispute or requiring further information, are considered due when the bill is received. We must hear from you in writing within 30 days from the original bill date if there are any questions or concerns. Otherwise the bill amount shall be considered accepted and entered as such on our books. In order to process your request properly we require a letter with your name and the account number, the dollar amount contested, and a brief description of the situation.
- In signing this form I consent to treatment by BTN for my illness and/or health evaluation and agree that no guarantees have been made to me as to the results/outcome of my medical care. I also acknowledge that signature of this form may be used as a waiver of liability for such treatment.

I have read and fully understand the financial policy set forth by and I agree to the terms of this financial policy. I also understand and agree that the terms of the financial policy may be amended by BTN at any time without prior notification.

Signature of Client/Responsible Party

DATE