PHYSICAL THERAPY OF LOS GATOS

15047 Los Gatos Boulevard Suite 180
Los Gatos, California 95032
P. 408/358-6505 • F. 408/358-6404

FINANCIAL POLICY AND PATIENT CONTRACT

Physical Therapy of Los Gatos is an "out of network" provider. We will bill your health insurance company for the physical therapy services rendered to you. Your insurance policy may provide payment that is less than our customary fee. While the filing of an insurance claim form is a courtesy that we extend to our patients, all charges for services rendered are your responsibility from the date of service. This document is a contract between yourself and Physical Therapy of Los Gatos. Payment may be made by cash, check, MasterCard or Visa.

CANCELLATION / NO SHOW POLICY: A minimum of twenty-four (24) hour notice to cancel or reschedule an appointment is required. A $50.00 charge may apply if proper notice is not given. This charge will not be paid by any insurance carrier.

INTEREST CHARGES: Services paid for in full within ninety (90) days of the service date are not subject to any interest charge. Patient is responsible for an interest charge of 1.5% per month (18% per annum) on all balances unpaid after ninety (90) days.

COLLECTIONS: Physical Therapy of Los Gatos has retained a collections agency to assist in collecting any past due balance. Should your account be referred out to this agency, please note that this will affect your credit rating and you will be responsible to them for interest incurred on the balance due.

I understand and agree, regardless of my insurance status, that I am ultimately responsible for the payment of services provided to me by Physical Therapy of Los Gatos. Initials: _____

I certify that I have read this document in its entirety and agree to the terms and conditions contained herein. A copy of this document will be available to you at any time. Initials: _____

PRINT YOUR FULL NAME: _____

PRINT PATIENT'S FULL NAME (If Different): _____

SIGNATURE: _____DATE:_____

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

I hereby authorize my insurance benefits, of any kind, to be paid directly to Physical Therapy of Los Gatos. I further authorize Physical Therapy of Los Gatos, to release my medical records or information to any insurance company, as necessary or required to process my insurance claims.

PRINT YOUR FULL NAME: _____

PRINT PATIENT'S FULL NAME (If Different): _____

SIGNATURE: _____DATE:_____