Action Physical Therapy Important Company Policies

We strive to provide you the best-personalized care available. To make this possible we adhere to a set of very important policies. Please read them carefully, initial all the underlines.

Cell phones must be shut OFF or silent. We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

Children requiring supervision are NOT allowed to attend sessions with you. You may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly, you may bring them in. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

Important Notice from the Federal Government: "It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. You may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA].

Home care *(for Medicare patients only*). I understand that **Medicare does not pay for outpatient Physical Therapy if it occurs at the same time as a Home Care episode.** I understand that I will be personally responsible for payment in full of all charges for physical therapy services if Medicare does not cover it due to having a home care episode.

Patient's Signature:_____ Date:_____

Please complete the following if the patient is *a minor or unable to consent.*

Name of person legally authorized to sign for this patient:

_____

Relationship to patient:_____

Signature of Authorized Person:_____

Date:_____