Dear New Patient:

Welcome to TriCore Physical Therapy!

Our goal is to provide you with top-quality physical therapy services. TriCore Physical Therapy strives to meet the therapy goals that your physician and our staff have determined to be appropriate for your case.

Your physician prescribed physical therapy so that you will be able to regain your strength, endurance, and your ability to function well in your daily life. You need to attend all of your therapy appointments for this to occur.

Our clinic is managed by Integra Rehab Solutions. Integra Rehab Solutions provides billing, accounting and operations services. If you have any questions about your care while you are in our clinic, please ask one of our clinical staff. If they are unable to fully answer your question, they will refer you to someone who can help you.

The following pages contain TriCore policies, procedures, and statements (notifications), regarding your care in our clinic, including:

- Statement of Privacy Practices
- Billing, Collection and Assignment of Benefits Policy
- Cancellations and No-Show Policy
- TriCore Authorization to Render Services
- Policy Regarding Personal Injury (Accident) Accounts

Please complete these forms before you begin your first physical therapy visit. Please give the signed and complete forms to the front desk at the beginning of your first physical therapy session.

We look forward to working with you and meeting your needs!

Sincerely,

Ryan Flipse, PT
TriCore Physical Therapy

Please Read, Sign, and Return to Front Desk

Billing, Collection, and Assignment of Benefits Policy

All of the billing for your physical therapy is done at Integra Rehab Solutions. At your first appointment you will receive a form confirming your insurance benefits. Your insurance company verified these benefits to Integra Rehab Solutions. Your benefit form will show your co-pay amount and/or the portion of your bill for which you are responsible. The front desk will ask you for this payment at the time of each appointment. It is out of concern for you and your account balance, that we will ask you to pay as you go, so that your account balance does not escalate. We will accept check, cash, or credit card (Visa, MasterCard and Discover). Should you have any questions regarding any billing issues, please call our billing office at 847.393.4501.

To Be Completed By The Patient:

I understand that I am financially responsible for all charges not covered by my insurance company. I agree that I will pay these non-covered charges as well as the costs and fees to collect uncovered amounts, should they be required and incurred. In addition, I have received a copy of and read the Statement of Privacy Practices, and I understand and agree to its terms.

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Insured's Signature Date

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Parent/Guardian Signature Date

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TriCore Representative Date

ASSIGNMENT OF BENEFITS

I further authorize direct payment of medical benefits to TriCore by carrier(s):

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Name of carrier(s)

Please Read, Sign, and Return to Front Desk

Cancellation and No-Show Policy

Your physical therapy prescription has been authorized by your Doctor so that you will be able to regain your strength, endurance, and your ability to function well in your daily life. This prescription should be treated as if it was a medication—you need to attend all of your physical therapy appointments. Though we understand that due to unforeseen events, there may be an occasion that you need to cancel an appointment, we ask that you make every effort to attend all of your scheduled appointments.

Following are our policies regarding cancellations and no-shows.

- Appointment Cancellation: we require 24 hour notice.
- Cancellation without 24 Hour Notice: $25 (twenty five dollar) charge may be assessed. Your personal insurance, Worker's Compensations or auto insurance does not cover the cancellation fee.
- Appointment No-Show: $25 (twenty five dollar) charge may be assessed. Your personal insurance, Worker's Compensations or auto insurance does not cover the cancellation fee.
- Involuntary Discharge: we reserve the right to discharge a patient from Physical/ Occupational Therapy under the following conditions:
    - The patient has missed two appointments without notice ("no-show")
    - The patient has cancelled two or more appointments without 24 hour notice

For Worker's Compensation patients, please note that documentation of any missed appointments, cancellations, and involuntary discharge will be forwarded to your case manager and this could jeopardize your claim.

To Be Completed By The Patient:
I have read the policies above, I understand these policies, and I agree to their terms.

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Patient Signature Date

Please Read, Sign, and Return to Front Desk

Authorization to Render Services – Informed Consent

The term "informed consent" means that the potential risks, benefits and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I understand that I am under no obligation to utilize the physical therapy services offered and owned by TRICORE.

I understand that I may seek treatment at a physical therapy provider of my choice and that alternative listings of physical therapy providers may be found in the classified section of the telephone directory under the appropriated heading.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me his/her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

To Be Completed By The Patient:

With full knowledge of the foregoing, I desire to utilize the physical therapy services offered by TRICORE.

Patient Signature Date

Please Read, Sign, and Return to Front Desk

Policy Regarding Services Due To Personal Injury (Accident)
Our policy regarding personal injury (accident) services is as follows:

1. Even though a third party insurance carrier or others may ultimately be responsible for the payment of medical bills and other damages that you may legally be entitled such as a result of your accident has no bearing or effect on your legal obligation to pay our medical bill. You are responsible for payment of our medical bill.
2. You must provide us with complete insurance carrier information (name, address, phone number and claim number). This includes the insurance carriers for all vehicles involved in the collision or all potential responsible parties.
3. If you have an attorney, we will need his/her name, address, and phone number.
4. If your balance remains unpaid after (60) days, you will be required to make regular monthly payments (amount to be determined at the time depending on balance) to keep your account current. You may collect from your insurance company or attorney when your case settles. If your insurance or attorney sends payment to us, we will reimburse you.

To Be Completed By The Patient:
I agree to the terms listed above. I understand that the charges I incur are solely my responsibility and I agree to make regular monthly payments in the event there is a delay in reimbursement due to litigation or other circumstances.

Patient Signature Date