"Trinity will strive to give you the very best care possible with exceptional customer service. We achieve results though education, encouragement, and enthusiasm. We sincerely appreciate you choosing Trinity PT and are thankful for the opportunity to serve you! Please tell others about your experience at Trinity and let us know how we can serve you better in the future."

Sincerely, Jeff & Holly

Please read the information below and sign when required. If you have any questions, please ask our office staff.

Consent for Medical Treatment:

I understand that I have been diagnosed with a condition that requires diagnostic and/or medical treatment. I consent to care from Trinity Physical Therapy, LLC as may be deemed necessary by their judgment, under the prescription of a licensed physician. Even though I expect that the care I receive will meet customary standards, I do understand that the practice of medicine has no guarantees and that the results of my treatment(s) and/or evaluation(s) have no guarantees as well. Also, if I refuse treatment that is suggested for me, I will not hold Trinity Physical Therapy, LLC or any individual responsible for any consequences resulting from my decision. I understand that Trinity Physical Therapy, LLC does not discriminate against any person on the ground of race, color, creed, national origin, religion, sexual orientation, age, gender, or disability. I also understand that Trinity Physical Therapy, LLC has the right to refuse treatment to any person who exemplifies disruptive behavior or who is threatening to our staff and/or clientele.

Patient Signature (or legal guardian): X______________________________

***Insurance information:** Trinity Physical Therapy, LLC will bill your insurance company as a courtesy to you. **It is your responsibility to know your policy benefits as well as limitations, deductibles, and copays.** Please provide your insurance card(s) and any additional information that we may need in order to bill your insurance for you. It is strongly recommended that you contact your insurance company directly to verify your Physical Therapy coverage so that there are no discrepancies between our office and what you thought your insurance would pay for. Most insurance companies provide a 1-800 number on the back on your card to assist you with customer service. Our office can help answer questions you may have regarding your insurance coverage and your bill.

***Payment options: Any portion of your treatment that is not covered by your insurance becomes your responsibility. Patients are required to pay applicable deductibles/copays at the time of service. As a service to you, we can set your account up for automatic bill pay using a credit/debit card.**

If you have financial concerns please address this with the front office staff at your initial appointment. A weekly or monthly payment plan can be arranged for you. Trinity Physical Therapy, LLC accepts cash, checks with appropriate information included, Visa, and MasterCard debit or credit cards**.**

Return check fees: A **$39.00** fee will be charged to the patient for each incident that a check is returned to us for insufficient funds.
Collection of accounts: A **$35.00** fee will be charged to the patient for any account turned over to a collection agency for non-payment. This fee is in addition to any and all other fees that have become delinquent.

Supplies: Supplies for home use are to be paid in full at the time the patient receives the supplies.

Work Comp. Cases/Claims: We will bill your open and approved workers' compensation claim for you. Understand that if your claim is denied you will be responsible for all charges. It is good practice for you, the patient, to maintain a relationship with your case manager and/or worker's compensation insurance adjuster.

Scheduling appointments: At the time of your first appointment we will work with you to build a schedule that meets your needs. Please understand that you are expected to arrive to each appointment on time and ready to begin your treatment. If you need to reschedule an appointment please call our office 24 hours in advance so that we can make you another appointment in a timely manner. This will also allow us to accommodate others who are waiting to be seen by the Physical Therapist. If you fail to attend your appointments you may be charged a non-refundable fee of **$25.00** and may be removed from our schedule. **It is important that you become committed to your treatment plan so that we can do our best to help you get better.**

I understand and agree to the policies listed above.

Patient Signature (or legal guardian) ______________________ Today's Date: ______________________