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. We will provide you with a weekly statement. Payment may be made by cash, check, MasterCard or Visa.

CANCELLATION 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. An interest charge of 1.5% per month (18% per annum) will be charged on all balances unpaid after ninety (90) days.

COLLECTIONS: Physical Therapy of Los Gatos has the right to use legal action, including but not limited, to small claims court to assist in collecting any past due balance. Should Physical Therapy of Los Gatos seek legal action any reasonable attorney costs will be your responsibility.

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.

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:_____

Physical Therapy of Los Gatos

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____ understand that as part of my health care, the Practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed you carry out treatment, payment or health care operations

I understand that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Practice reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the Practice change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or , if I agree, email).

I wish to have the following restriction to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient's signature Date

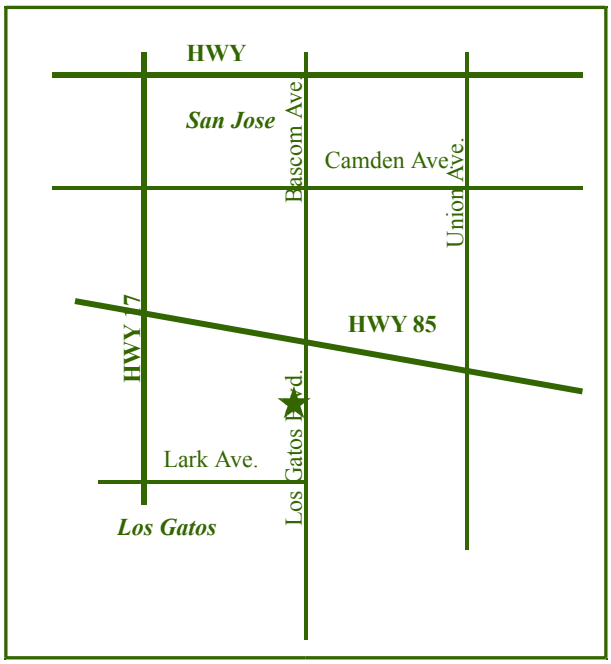
GETTING TO
Physical Therapy of Los Gatos

From Hwy 17: Take the Lark Ave Exit east. Travel east to Los Gatos Blvd. Turn north (left) onto Los Gatos Blvd. Travel approximately 1/8 mile. 15047 will be on your left just before the Boulevard Tavern. We are in suite 180.

From Hwy 85: Take the Los Gatos Blvd/Bascom Ave. exit. Travel South 1/8 mile toward Los Gatos. 15047 will be on the right, just past the Boulevard Tavern. We are in suite 180.

Our office is in the two-story Los Gatos Medical Center. Parking is available behind and under the building. There are 2 entrances in the building. One is in the front and the second is in the back. To get to our office from the back entrance you may take the elevator or stairs up one level. Then follow the signs for the "Lobby".

Clinic Hours:
M-W-F: 8 am to 5 pm
T-Th: 8 am to 6 pm,
Sat Appointments are available



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