Registration Agreement

Phone: 703-443-6700 Fax: 703-443-6702

525-B EAST MARKET STREET, LEESBURG, VA 20176 OR

44125 WOODRIDGE PARKWAY, SUITE 280, LANSDOWNE, VA 20176

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PATIENT'S NAME

1. **MEDICAL CONSENT - The** undersigned consents to treatment and procedures which may be performed during the physical therapy sessions, with Loudoun Physical Therapy, Inc. (LPT) personnel under the general and special instructions of the patient's physicians or surgeons.
The patient has a right to know the identity of those providing patient care including students, to refuse any treatment, and to be informed of the possible medical consequences of refusal. My signature on this document indicates my General consent to be treated. My therapist and/or members of the Loudoun Physical Therapy, Inc. may request that I sign a more specific form relative to any procedure which may be performed.

2. **RELEASE OF INFORMATION** - Loudoun Physical Therapy, Inc. and/or the therapists providing services in the Loudoun Physical Therapy facility may disclose any or all parts of my medical records to my insurance carrier(s) and any organization(s) contractually responsible for purposes of satisfying all charges billed by Loudoun Physical Therapy. In addition, I authorize Loudoun Physical Therapy, to disclose any or parts of my medical records to any organization(s) for the purpose of arranging continuing care deemed necessary, I further understand that it may be necessary for Loudoun Physical Therapy, the therapists, and/or the business staff to contact my/our past or present employer(s) in regard to any insurance claim.

3. **REFERRAL AND PRECERTIFICATION REQUIREMENTS** - I hereby take full responsibility for all referrals and pre-certification requirements as described or requested by my insurance company. I understand it is my duty and responsibility to contact the insurance company to make certain that the referrals have been issued. I further understand that failure to provide referral or pre-certification information to Loudoun Physical Therapy could result in reduced or rejected coverage and that I will take full responsibility for payment of all balances due.

4. **FINANCIAL RESPONSIBILITY** - The undersigned agrees and personally guarantees, in consideration of services and materials provided by the Loudoun Physical Therapy, Inc. or the therapists to be responsible for payment in full of all Loudoun Physical Therapy, Inc. bills and/or therapist's bills. (In the event that any unpaid accounts are turned over to an attorney or collection agency for collection, that I shall pay one hundred percent (100%) attorney's fees; interest on the unpaid principal balance at the rate of eighteen percent (18%) per annum; and all other legal fees and collection agency's costs pertaining to this encounter). Payment by the patient of their portion of the bill (co-payments, percentage, and deductible) is due at the time of each visit. If you choose not to have claims filed by our office, full payment is due at the time of each treatment rendered.

5. **CANCELLATION POLICY** - If you are unable to keep your appointment, to avoid any cancellation fees you will need to call by
(Noon 12:00p.m the day prior to your given appointment time) on LPT normal business days (excluding holidays).
Late cancellation, no shows and late arrivals after 20 minutes will be charged a **fee of $50.00**. Your missed appointment could be someone else's appointment. If you late cancel or no show three (3) times within the course of your treatment, you would be automatically discharged and we will not accept you back to our practice.

6. **PERSONAL VALUABLES** - I hereby release Loudoun Physical Therapy, Inc. from any responsibility for valuables, money, personal or other possessions which are brought in by the patient at the time of treatment. Loudoun Physical Therapy, Inc. assumes NO responsibility for the safety of dentures or eyeglasses as these must be available for patient's daily use.

7. **THERAPISTS** - The undersigned recognizes that all therapists furnishing services to the patient bill under the group name of
Loudoun Physical Therapy, Inc.

8. **OTHER CONDITIONS** - The undersigned further states that the foregoing Registration Agreement has been carefully read, and that he/she knows the contents thereof, and has signed as his/her own free and voluntary act, and has not been influenced in executing this Registration Agreement by any representative of Loudoun Physical Therapy, Inc. or its agents. I hereby acknowledge the continuing nature of this agreement unless or until withdrawn in writing by me.

9. **ASSIGNMENT OF BENEFITS - The** undersigned hereby authorizes Loudoun Physical Therapy to apply for benefits on my behalf for services rendered by Loudoun Physical Therapy and request that the payments are made directly to LPT. I certify that the information I have reported about my insurance coverage is correct. I also authorize the group to release all necessary information including medical information for this and any related claim, in order to determine benefits to which I am entitled. I permit a copy of this authorization to be used in place of the original.

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(Name of health insurance, i.e. Medicare, HMO, PPO, Anthem, Blue Cross, Worker's Compensation, etc).

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PATIENT/PARENT OR GUARDIAN SIGNATURE DATE