KETHLEY
Physical Therapy

800 Hwy 290 West, Ste. B-300
Dripping Springs, TX 78620
Phone: 512-858-5191 Fax: 512-858-5194
www.KETHLEYPT.com

Consent for Treatment:

I understand, consent, and agree that I will be seen, evaluated and treated by a licensed physical therapist. I further understand that I may also be seen upon occasion by a fully trained and qualified associate under the guidance and direction of the licensed physical therapist.

Patient/Guardian: _____ Date: _____

Insurance Authorization/Financial Policy:

It is the policy of Kethley PT to file claims with your health insurance as a courtesy and convenience to you. Once you have given us your policy information, we will verify your physical therapy coverage. **Please be advised that the information provided to us by your insurance company is only a quote of benefits and not a guarantee of payment.** We will collect an estimation of our financial responsibility (co-pays, co-insurance, deductibles, etc) based on what your insurance company quotes us before your claims are submitted. It may be necessary to adjust the amount due once an actual explanation of benefits is received from your insurance company. **We highly recommend that you also call your insurance company in order to confirm your benefits for physical therapy.** I authorize Kethley PT to release medical information that may be necessary to request reimbursement from my insurance company. I assign all medical benefits to Kethley Physical Therapy for the claims that were submitted to my insurance company. This assignment will remain in effect until revoked by me in writing.

Patient/Guardian: _____ Date: _____

Cancellation/ No Show Policy:

We respectfully request that if you must cancel an appointment please kindly give us 24 hours advance notice. Otherwise, we may charge a $25 no-show/cancellation fee ($50 for pelvic floor).

Patient/Guardian: _____ Date: _____

Acknowledgement of Review of Notice of Privacy Practices (HIPAA):

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient/Guardian: _____ Date: _____