ACCELERATE
THERAPY & PERFORMANCE

Payment Policy and Financial Agreement

Thank you for choosing Fowler Physical Therapy, dba “Accelerate Therapy and Performance” for your Physical Therapy needs. This financial agreement describes both patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have and sign in the space provided.

By signing below I am acknowledging that I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection agency. If it becomes necessary to send my account to a collection service, You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys’ fees, we incur in such collection efforts.

Insurance

Your insurance coverage is a contract between you and the insurance company and we are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. It is also your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. As a courtesy we will submit your claims to your primary and secondary insurance companies however we do expect payment for all services within 60 days. It may become necessary for you to pay your account in full if your insurance fails to do so within 60 days. If we are given incorrect or incomplete insurance information you will be billed and payment will be expected within 30 days, unless the issue is resolved.

Patient Responsibility & Payment

Payment of copays and deductibles will be due at time of service. Our failure to collect these amounts may be a violation of our contract with your insurance company. You are ultimately responsible if your insurance denies a claim for any reason. If you do not have insurance payment in full will be due at time of service. The amount of your bill is expected to be paid in full within 30 days of the date on the statement, unless payment arrangements have been made with the Billing and Accounts Manager, or Billing Coordinator. Anything over 30 days is considered past due.

Payment Options – Credit Card on File

For your security and protection, Accelerate Therapy and Performance stores your encrypted and tokenized credit card data in an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards.

I authorize Accelerate Therapy and Performance to automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees.

I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify Accelerate Therapy and Performance of any updates or changes to the credit card on file associated with this agreement as soon as possible.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which will affect your credit. NSF checks will result in a $25.00 returned check fee.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

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Missed Visit/Attendance Policy

At Accelerate Therapy & Performance, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. We are happy to share a copy of this study with you but want to make sure that you understand that it is extremely important that you attend all of the appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. Please note: Our goal is to begin your treatment sessions on schedule. For all appointments after your evaluation, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. If you're running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 5 minutes late, your session may need to be rescheduled and if that occurs, you will incur a missed visit charge. Chronically late patients will be asked to change their appointment times.
5. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment.
6. Providing care to all patients is extremely important to us and late notice of changes or cancellations will keep someone else from getting the care they need and deserve. **If you need to cancel or change a scheduled appointment, for any reason, we require you to contact us by closing the business day before, so we have enough time to help another patient who needs to get in for the care they need and deserve.**
7. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
8. **We reserve the right to charge a missed visit fee of $50.00 if you do not provide at least a days' notice of your appointment change or cancellation and will comply with payer policy in carrying it out**
9. To avoid our missed visit fee, we need you to call our office **during business hours** - to avoid issues with our policy.
10. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule and will be placed on the day-to-day list to avoid future missed visit charges. We will also notify your physician of your non-compliance.
11. If you're a worker's comp patient, we are required to notify your claims adjuster if you cancel or no-show for an appointment.

We look forward to working with you to meet your physical therapy goals. To avoid any issues with our policy, we only need the required notice, so we have enough time to help all patients to get in for the care they need and deserve.

This policy has been reviewed with me and by signing below I am indicating that I understand this policy.

Patient Signature	Patient Name	Date

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Patient Consent for Physical Therapy Services

Thank you for choosing Accelerate Therapy and Performance. This document outlines the terms and conditions of receiving physical therapy services at our practice. Please read it carefully and sign at the bottom to indicate your understanding and agreement.

Purpose of Consent

By signing this form, you acknowledge and agree to receive physical therapy services provided by licensed physical therapists and/or other qualified staff at Accelerate Therapy and Performance.

Nature of Treatment

Physical therapy involves the assessment, diagnosis, and treatment of physical conditions that impair movement, function, and overall well-being. Treatment may include, but is not limited to:

- Therapeutic exercises
- Manual therapy techniques
- Modalities (e.g., heat, ice, ultrasound, electrical stimulation, vasopneumatic compression, dry needling, therapeutic laser)
- Education and instruction in self-care
- Other interventions deemed appropriate by your physical therapist

Risks and Benefits

The goal of physical therapy is to improve your physical function and quality of life. While generally safe and effective, physical therapy interventions may carry risks, including but not limited to:

- Temporary discomfort or soreness
- Aggravation of pre-existing conditions
- Unintended reactions to therapeutic modalities

If you have any concerns about your treatment plan or its risks, please discuss them with your physical therapist.

Patient Responsibilities

For optimal outcomes, patients are expected to:

- Provide accurate and complete information about their health history and current condition.
- Follow the treatment plan and instructions provided by the therapist.
- Inform the therapist of any changes in condition or adverse reactions during or after treatment.

Confidentiality

Your medical records and personal information will be kept confidential and used only for purposes of providing care, billing, and compliance with legal requirements. Accelerate Therapy and Performance complies with all applicable laws and regulations regarding patient privacy.

Financial Responsibility

By signing this form, you acknowledge that you are financially responsible for the cost of physical therapy services, including any co-payments, deductibles, or non-covered services as determined by your insurance provider.

Patient Initials_____

Patient Consent for Physical Therapy Services (Continued)

Right to Refuse or Discontinue Treatment

You have the right to refuse or discontinue treatment at any time. Likewise, Accelerate Therapy and Performance] reserves the right to discontinue services if we determine that continuing treatment is not in your best interest or if you fail to comply with your treatment plan.

Acknowledgment and Consent

By signing below, I acknowledge that I have:

- Read and understand this Consent to Treatment Policy.
- I had the opportunity to ask questions and receive satisfactory answers.
- Provided accurate and complete health information to my physical therapist.

I voluntarily consent to receive physical therapy services at Accelerate Therapy and Performance and understand that I may withdraw my consent at any time.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Privacy and Patient Bill of Rights

Accelerate Therapy and Performance understands that you have read and are aware of the current rules and regulations regarding Patient Rights and Responsibilities. If you are unaware of these policies, please ask us for a copy. Any changes to the HIPAA Privacy Act, effective April 14, 2003, or patient rights will be posted in our office.

Acknowledgment

By signing below, I acknowledge that I have received and reviewed this Patient Bill of Rights. I understand my rights as a patient at Accelerate Therapy and Performance and agree to communicate openly with my care team to ensure the best possible outcomes.

I agree to and understand the above policies:

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Marketing Consent Form

I, _____, a patient at Fowler Physical Therapy Inc. dba “Accelerate Therapy & Performance”, “ATP”, understand the following

- ATP is preparing marketing materials (videos, newsletters, newspaper inserts, online, social media) that demonstrate the success and results of the physical therapy it provides
- ATP will provide copies of the material to potential referring physicians, as well as to individuals who are potential patients;
- In order to create the materials and demonstrate the results obtained by ATP patients, it is necessary for ATP to take photos and audio/ video recordings of patients prior to, during and following the treatments I receive at ATP;
- I have been asked and I have agreed to appear in the materials;
- Therefore, ATP will take photos and audio/video recordings of me prior to, during and after the treatment I receive from ATP;
- ATP will incorporate the photos and audio/video recordings mentioned above into the materials;
- My likeness and/or name will appear on the materials;
- The condition for which I am being treated in ATP may be expressly stated in the materials;
- I hereby authorize ATP, its employees, agents, officers and directors to photograph, film, videotape, record and/or portray my name, likeness, voice and/or actions prior to, during and after the treatment that I receive in ATP and incorporate the same in the materials that are to be used for the marketing purpose. I also authorize ATP to incorporate my diagnosis into the materials, along with other information such as ATP believes to be appropriate. I waive any right you may have to inspect or approve the incorporation of photos and audio and video recordings of me into this material. I understand all rights to the material authorized above, including copyrights, will remain the property of ATP solely and absolutely.

I understand that ATP cannot control the future diffusion of the material after I leave ATP control. In agreement, it released ATP from any responsibility related to the dissemination of the materials.

I understand that I can revoke this authorization at any time. My revocation will have to be made in writing and sent by certified mail to Fowler Physical Therapy Inc dba Accelerate Therapy & Performance, 1508 W. Innes Salisbury, NC 28144. However, ATP will still be authorized to distribute any copies of the materials that it has produced through the end of the day. on which ATP receives my revocation.

I agree that I have read and understand this Authorization and that I am at least 18 years of age and with the intention of being legally bound by this means, I place my hand and stamp on the date written below.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

❒ I wish to OPT OUT of this program Signature: _____ Date: _____