West Bay Physical Therapy

700 S. Claremont St #105   San Mateo, Ca. 94402   650-342-7887

West Bay Physical Therapy

Patient Acknowledgement Form

I have read and fully understand West Bay Physical Therapy's Notice of Information Practices. I understand West Bay Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that West Bay's Physical Therapists will consider requests for restriction on a case by case basis, but do not have to agree to requests for restrictions.

I understand that I may have a copy of the Notices of Privacy Procedures at my request.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in West Bay Physical Therapy's Notice of Information Practices. I understand that I retain to revoke this consent by notifying the practice in writing at any time.

Print Name: ______________________________________

Sign Name: ______________________________________

Date: ____

If applicable, reason patient's written acknowledgement could not be obtained:

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Patient Name: ______________________ SS#___________________ Date of Birth_________

FINANCIAL POLICY

We are committed to providing you with the best possible care. As a courtesy to our patients, we will also submit your insurance claims for you. Please understand that you are responsible for your bill for services, in its entirety. If you would like us to submit bills to your insurance company on your behalf, please provide us with a copy of your insurance card and complete billing information. Incomplete information may lead to payment delays or your claims being denied by your insurance carrier, which will necessitate us billing you for any outstanding balance. Please verify that we are contracted with your insurance carrier. Please understand that it is your responsibility as the patient to know your own insurance coverage.

Payment is expected at the time of service for any amount determined to be uncovered by your insurance. (i.e. percentage coverage plans, co-payments and deductibles).

In the event that you do not have medical insurance, payments will be expected at the time of service. We realize that temporary financial problems may affect timely payment of your account. If this situation should occur please contact us immediately to assist you with the management of your account. **There will be an 18.0% interest charge for any balance 180 days past due or 1. 5% per month on all past due accounts.**

The nature of this office is to give you personal, individual care and a reserved appointment time. Thus, we request at least a 24-hour notice of cancellation or change of appointment. **Due to the length of time we schedule with our patients, there will be a $40.00 fee charged for any broken appointments without proper notice.**

I hereby instruct and direct ___________________________ Insurance Company to pay by check made out and mailed to West Bay Physical Therapy, **700 S. Claremont Street, Suite 105, San Mateo, CA 94402. This is a direct assignment of my rights and benefits under this policy.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I also authorize the release of any information pertinent to my case to any insurance adjuster, or attorney involved in this case.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I have read, understand and agree to the above financial policy. In addition, I authorize West Bay Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at San Mateo, CA _________ day of __________, _____________.
Day Month Year

____________________________________ ____________________________________
Signature of Patient / Policy Holder Witness

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Signature of Claimant, if other than Policyholder