



Clinic Policy and Financial Agreement

Consent for Care and Treatment

I give my consent for the physical and occupational therapists of Olympic Sports and Spine Rehabilitation, P.S. to furnish medical treatment as prescribed and considered therapeutically necessary on the basis of the findings during the course of treatment. I authorize direct payment for services to Olympic Sports and Spine Rehabilitation, P.S.

Medical Records Policy

We keep a record of the health care services provided to you. You may ask to see that record, however, a member of our Compliance Committee must be present. You may also ask to have your records corrected. The insurance company you ask us to bill may wish to see your records as a requisite to processing your claim. We will not disclose your records to others without a signed medical release from you or unless the law authorizes or compels us to do so.

Financial Policy

A medical insurance policy is a contract between you and your insurance company. OSSR is contracted with most insurance companies and agrees to submit your bills directly to them. In order for us to bill your insurance company, we will ask for a copy of your insurance card. All patient co-payments are due at each office visit. We do not bill for co-payments unless prior arrangements have been made with our Corporate Office. In the event it becomes necessary to refer this account for collection, I agree to pay attorney fees and collection costs.

Motor Vehicle Collisions

We will bill your Personal Injury Protection Insurance (PIP) as a courtesy to you. However the patient is fully responsible for the bill. In the event that payment has not been made within 30 days, the patient will be required to make payment arrangements until the time of settlement, judgment, or payment by attorney or the automobile insurance company.

Department of Labor and Industries

As an injured worker, I understand that my physical and occupational therapy will be covered by the Department of Labor & Industries. However, if my claim is denied for any reason, I understand that I will be fully responsible for the total cost of my care.

In consideration of physical and/or occupational therapy services rendered to the patient noted below, I agree to pay all amounts due which are not paid by insurance on this account.

Date

Patient Name

Signature of Patient or Guardian