Dynamic Life
Therapy & Wellness, PC

Consent for Treatment

I hereby give my consent to receive treatment by a licensed Physical Therapist, Occupational Therapist, Physical Therapist Assistant, and/or Fitness Instructor of Dynamic Life Therapy and Wellness, PC based on my individualized treatment and medical needs.

Authorization to Release Payment and Information

I request that payment of authorized insurance benefits be made on my behalf to Dynamic Life Therapy and Wellness, PC for any services furnished to me by a rehabilitation provider. I authorize any holder of medical information about me to be released to my insurance carrier and its agent for information needed to determine these benefits or the benefits payable for related services.

Our Payment Policy

Dynamic Life Therapy and Wellness, PC believes both the patient and the provider benefit from clear communication regarding financial agreements. As a service to you, our office will bill your insurance for services rendered. However, the undersigned is primarily responsible for all non-covered expenses, which may include but not be limited to co-payments, co-insurance or deductibles from his/her insurance. If you elect to self-pay, cash discounts are available on applicable services and insurance will not be billed by our office. Balance on account is due upon receipt of statement, or payment arrangements can be set up with our office. The undersigned agrees that failure to pay or set up payment arrangements after three (3) consecutive statements will result in the account being assigned to a collection agency for bad debt recovery.

The patient is responsible to inform Dynamic Life Therapy and Wellness, PC of any previous physical, speech or occupational therapy received during the calendar year. Medicare has a $2,040 therapy cap for combined outpatient physical and speech therapy services, as well as an additional $2,040 cap for occupational therapy. If the patient does not inform Dynamic Life Therapy and Wellness, PC of such previous services received, the patient will be expected to pay in full the billed amount not covered by Medicare, supplement, or private insurance.

Reminder of appointments

Dynamic Life Therapy and Wellness, PC offers text or e-mail reminders.
Please send me a text message reminder___
Please send me an email reminder___
Our office policy requests a 24-hour cancellation notice, if you are unable to make your appointment.

By signing below, you certify that you have read and understand the above agreements.

_____ _____

Signature of patient, parent/legal guardian or power of attorney

Date

_____

Signature of witness/staff