BLUE BELL PHYSICAL THERAPY
FINANCIAL WAIVER AND SURVEY ACKNOWLEDGEMENT

Patient name_____ ID Number_____

Thank you for choosing Blue Bell Physical Therapy for your rehabilitation needs. You can expect quality, hands on, personalized care that will generate results. In exchange, we expect that, after undergoing a full explanation, you understand your financial responsibility. This responsibility obligates you to ensure payment in full of our fees. We will verify your insurance coverage and bill your insurance carrier on your behalf. By doing so, we will meet our obligation to ensure that your insurance carrier has all the necessary information to make payments on your behalf, however, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as stated by your contract with your insurance carrier. We expect these payments when services are rendered. Please be aware that some insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your carrier. If your insurance carrier denies any part of your claim, or, if after consulting with your physician, the need exists to continue therapy beyond the approved coverage by your insurance carrier, you will be responsible for your account balance in full.

Your coverage has been verified for treatment of:

Diagnosis_____

Patient Responsibility_____

Insurance Responsibility_____

I have read the above policy regarding my financial responsibility to Blue Bell Physical Therapy for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits to Blue Bell Physical Therapy. I also agree to pay Blue Bell Physical Therapy the full and entire amount of all bills incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

PATIENT SIGNATURE:_____DATE:_____

GUARANTOR SIGNATURE:_____DATE:_____
(if guarantor is not the patient)

CONSENT FOR TREATMENT

I understand that I have been referred for rehabilitation treatment to Blue Bell Physical Therapy. BBPT will design for me my individual treatment plan and I understand that I have the right to ask and have any questions answered prior to receiving treatment. This includes any risks or alternatives to the treatment plan that has been prescribed for me. By signing, I consent to have BBPT provide treatment under the direction prescribed by my referring physician, dentist , podiatrist and/or by my therapist.

Signature: _____ Date:_____

Guardian Signature:_____Relationship:_____

SURVEY ACKNOWLEDGEMENT

Surveys are being distributed to our patients to assist us in our ongoing efforts to provide effective treatment options and high quality care.

At the conclusion of your visit, please take a moment to complete the attached brief questionnaire and place it in the white privacy envelope provided. Please seal the envelope and return it to our receptionist before leaving the office.

Your responses will be held in strict confidence and results will be tabulated by Expert Clinical Benchmarks interprets patient comments regarding treatments and levels or care and develops objective reports for our clinical care team. This information becomes a valuable resource and one that supports our continual quality improvement efforts.

In an effort to determine how to allocate our marketing resources more effectively, please tell us how you heard about us:

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Your comments are important to us and we appreciate your assistance.