Blackstone Valley Physical Therapy Services, Inc.
670 Linwood Ave Suite 2
Whitinsville, MA 01588
P: (508) 234-7544 F: (508) 234-8002
www.bvpts.com

Payment Information

We are pleased that you decided to trust us with your physical therapy care. We are hopeful that your experience with us will be outstanding from start to finish. The following is some information in regard to the finances of your visit.

Payment Policy
Payment for physical therapy treatment is ultimately the responsibility of the patient. You are encouraged to contact your health insurance carrier to find out what your physical therapy benefit, or coverage is, based on your policy. We will verify your benefit as well and file claims on your behalf to your insurer. Should your health insurance coverage expire or terminate while you are still being treated, let us know and further options will be discussed. We will charge a $30 fee for billed balances that are delinquent at 60, 90, and 120 days. For those with HSA/HRA, we understand that payment may be delayed, and will work with all parties to try to obtain prompt payment. The patient is responsible for any collection costs, should the use of a collections agency be required to receive payment on your account. For Workers Compensation cases or Motor vehicle accidents, we will bill third-party payers as a courtesy.

Co-payments, Co-insurance, and Deductibles
Our front office will verify your physical therapy insurance benefits prior to your first visit. This will be reviewed with you on your first visit. We require that payments be paid at the time that our services are rendered, unless other arrangements have been made. Co-insurances (typically a percentage of the allowed insurance payment) and deductible responsibility will be estimated at the time of service. We encourage you to make a payment at each visit to avoid accruing a large balance, and once the explanations of benefits (EOB's) are received, we will review the balance and adjust accordingly. Cash, check and MasterCard/Visa are acceptable forms of payment. There is a $10.00 minimum fee on returned checks.

Cancellations
We are aware that at times you may be unable to attend your scheduled visits. As a courtesy, please give us at least 48 hours notice if you need to cancel your visit. This will allow us to provide care to another patient that may be waiting for treatment. Attendance of your scheduled visits is critical to allow us to consistently treat you and maximize your gains from physical therapy. Your physical therapist will review with you our Attendance Policy on your first visit.

Thank you for giving us the opportunity to serve you. Please feel free to ask us any questions about our services, policies and fees.

_____ _____
Print patient name Date

_____
Patient Signature (Parent or Guardian if patient is less than 18 years of age)

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Informed Consent Physical Therapy Care

I, hereby agree to a physical therapy evaluation and routine treatment by a Massachusetts licensed physical therapist or under his/her supervision, a Massachusetts licensed physical therapy assistant. I understand that the physical therapy treatment will be provided for the identification, prevention, remediation, and rehabilitation of an acute or chronic physical dysfunction. I understand that my physical therapist/physical therapist assistant will have me involved in the decisions of my care at all times. My consent to any treatment set forth is voluntary and I may withdraw any such consent at any time and to any aspect of the prescribed treatment.

Benefits to be expected
Although no assurance can be given and every case is individual, common benefits associated with regular participation in a physical therapy program include, but are not limited to, improvement in joint range of motion/flexibility, muscle strength, cardiovascular endurance, physical performance, body mechanics, decreased pain levels, and reduction in future injury risk with the primary goal to restore maximum functional independence.

Risks and Discomforts
As with any medical procedure or treatment there are risks. These include abnormal blood pressure, fainting, disorders of heart rhythm, excessive perspiration and, in very rare instances, heart attack, stroke or death. Every effort will be made to minimize those risks by the initial examination/evaluation and by observations during the therapy sessions. If you have any concerns or questions about a particular portion of the proposed treatment, please notify your physical therapist or physical therapy assistant and he/she will address these issues.

Your responsibility as a patient
To gain the expected benefits of treatment, you must give priority to regular attendance and adherence to prescribed amounts of intensity, duration frequency, progression and type of activity and will report any unusual symptom(s) which you may experience before, during, or after a physical therapy treatment session.

Authorization to Release Information/Record Requests
In order to make informed decisions regarding your physical therapy treatments, it is helpful for your physical therapist to have access to your medical records. By initialing the box below, you authorize release of your medical, hospital, or surgical records to BVPTS pertinent to your physical therapy treatment, including but not limited to imaging, exams, surgical reports, special tests, or lab results. In addition, I authorize the release of my physical therapy treatment information to insurance companies or attorneys as needed to facilitate approval or payment, with the exception of the following:

_____ ☐ Please Initial

I have read, or have had read to me the above consent. By signing below, I agree to, or agree to have my child, receive routine physical therapy treatment as explained to me by the treating physical therapist. My signature also attests to the fact that I have been given Patient's Rights and Responsibilities and Notice of Privacy Practices and been given ample opportunity to review it. I intend this consent to cover the entire course of treatments for my condition for which I seek treatments from BLACKSTONE VALLEY PHYSICAL THERAPY SERVICES, INC.

_____ _____
Print patient name Date

_____
Patient Signature (Parent or Guardian if patient is less than 18 years of age)