POLICY REGARDING NO-SHOWS AND CANCELLATIONS:

POWER CENTER
PHYSICAL THERAPY
AQUATICS AND WELLNESS

Cancellations are REQUIRED to be made at least 24 hours before the appointment. Please note that our office charges $40 for "NO SHOW" and $25 for cancellations within 24 hours of the scheduled visit. An appointment is a RESERVED time that may be filled by someone waiting in line, so courtesy is EXPECTED in case cancellation or re-scheduling is necessary. Any FUTURE APPOINTMENTS will be cancelled after a NO-SHOW appointment, unless YOU confirm the next appointment via the automated text or a phone call / voice message.

Also, please note that we do our best to assign your appointment to your therapist of choice, but this is not *guaranteed*. Changes may be made to allow for efficient delivery of patient care.

Patient Acknowledgement: _____

V01.4/25

POWER CENTER
PHYSICAL THERAPY
AQUATICS AND WELLNESS

Patient's Name: _____

IMPORTANT COMPANY POLICIES

IN ORDER TO PROVIDE YOU WITH THE BEST POSSIBLE CARE, PLEASE ADHERE TO THE FOLLOWING POLICIES: (INITIAL ALL BOXES)

☐ PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY PCPT STAFF. (COPAYMENT, CO-SINSURANCE, DEDUCTIBLE)

☐ A $25.00 FEE APPLIES FOR ALL RETURNED CHECKS. BALANCES OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION FEES AND INTEREST CHARGES OF 1.5% PER MONTH.

☐ APPOINTMENTS CANCELED WITHOUT PROVIDING 24 HOURS NOTICE, WILL BE CHARGED A $25.00 FEE. IF YOU "NO SHOW" FOR YOUR SCHEDULED APPOINTMENT A $40.00 FEE WILL CHARGED. NO FURTHER APPOINTMENTS WILL BE MADE UNTIL THESE FEES ARE PAID.

☐ YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS. SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER.

☐ OUR FEES FALL WITHIN THE ACCEPTABLE RANGE BY MOST COMPANIES, AND THEREFORE ARE COVERED UP TO THE MAXIMUM ALLOWANCE DETERMINED BY EACH CARRIER. THIS APPLIES ONLY TO COMPANIES THAT PAY A PERCENTAGE SUCH AS 50% OR 80% OF "U.C.R". "U.C.R" IS DEFINED AS USUAL, CUSTOMARY, AND REASONABLE. (THIS STATEMENT DOES NOT APPLY TO COMPANIES THAT REIMBURSEMENT BASED ON AN ARBITRARY "SCHEDULE" OF FEES, WHICH BEARS NO RELATIONSHIP TO THE CURRENT STANDARD, AND COST OF CARE IN THIS AREA.)

☐ I HAVE READ THE **STATEMENT OF PRIVACY NOTICE**.

☐ I ACKNOWLEDGE THAT MY TREATMENT PROGRAM HAS BEEN EXPLAINED AND ALL OF THE QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND THE RISKS ASSOCIATED WITH A PROGRAM OF PHYSICAL THERAPY AS OUTLINE TO ME, AND I WISH TO PROCEED.

I HAVE READ AND AGREE TO THE INSURANCE AUTHORIZATION / ASSIGNMENTS OF BENEFITS AND THE POLICIES MENTIONED ABOVE.

Patient's Signature: _____ Date: _____

A. Notifier: *Power Center Physical Therapy Inc.*
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. *PT* **below, you may have to pay.**
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
PT = Physical Therapy or any Services received from Power Center Physical Therapy Inc.	• *Home Health Services / Episode* • *Maxed Benefit Allowance* • *Not Covered During Time of Service*	*$75 to $100 per Date of Service*

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** *PT* listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** *PT* listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** *PT* listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.** *PT* listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

POWER CENTER
PHYSICAL THERAPY
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (Name of facility/Doctor):_____
Address: _____to disclose the following information from the Health records of: Patient Name: _____ Date of Birth: _____
Address: _____ Telephone Number: _____

Covering the period of healthcare:
From: (date) _____ To: (date) _____

(2) Information to be disclosed: **COPY CHARGES**

D Complete health record(s)
OR if partial health record:
D Chart Inspection
D Consultation Reports
D Other (Please specify) _____
D SOAP Notes
D Progress Notes
D Laboratory
D X-Ray

(3) This information is to be disclosed to:
Name: _____
Address: _____
For the Purpose Of: _____

(4) I understand this authorization may be revoked in writing at any time, except with respect to action that has already been taken in reliance on this authorization. Unless otherwise, revoked this authorization will expire on the following date, event, or condition: _____

(5) I further understand that I have a right to inspect the protected health information to be used or disclosed, and to receive a copy of this authorization upon my request:
Copy requested and received: ___ YES ___ NO Initials_____

(6) The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(7) Information used or disclosed to any entity other than a health plan or health care provider may no longer be protected by the federal privacy law.

Patient Signature: _____ Date: _____

Or

Legal Representative Signature: _____ Date: _____
Relationship: _____

P.O. BOX 3250, VICTORVILLE, CA 92393 • TEL. # 760.245.8828 •FAX # 855.891.9996
E-MAIL: ADMIN@POWERCENTERPT.COM • WEBSITE: WWW.POWERCENTERPT.COM