

 **Financial Policy and Consent**

1. **Fee for service:** I acknowledge and understand that I am financially responsible for paying in advance for each session at a rate of **$185.00** for a physical therapy initial evaluation and **$150.00** for all follow up sessions. All treatment sessions are booked for 45 minutes to allow for documentation, follow up scheduling and transition to the next appointment. If you arrive late for your scheduled appointment whether in person or virtual, Form & Motion Physical Therapy (“FMPT”) will shorten the 45-minute session to end at the scheduled time. For this reason, we strongly suggest that you arrive for your appointment 5 minutes early to ensure maximum benefit.
2. **Cancellation and Appointment Reminders:** I agree to provide a minimum of 24-hours’ notice to cancel or change an appointment, whether physical therapy or fitness training. I understand that it is the policy of FMPT to charge a $25 fee for missed appointments or cancellations with less than 24hours’ notice (“late cancellation fee”). If I am ill or have an extenuating circumstance, FMPT may extend a one-time courtesy waiver of the $25 late cancellation fee. This waiver is at the sole discretion of FMPT. After one waiver has been granted, the $25 late fee will be charged. Full payment for the session will be due for the 3rd missed appointment or late cancellation. FMPT reserves the right to discharge a patient for recurrent missed appointments/late cancellations.
3. **Cash Based Practice:** I acknowledge that FMPT is an out-of-network provider for all commercial insurance companies and/or Medicare/Medicaid. I understand that I will be responsible for submitting claims to my insurer and will not expect to be credited by FMPT for any claim denied or not reimbursed. By signing below, I hereby agree that I will and are not seeking physical therapy from FMPT related to a workers compensation claim, personal injury, auto accident, or other legal proceeding.
4. **Forms of accepted payment:** Cash, personal checks, all major credit cards. In the future, there may be an electronic payment option such as PayPal or Venmo.
5. **Medicare/Medicaid Not Accepted:** I hereby acknowledge that I have been notified that FMPT is NOT a Medicare /Medicaid Participating Provider. I understand that neither I nor FMPT may submit claims for reimbursement for any services performed by Ingrid Ratz, DPT, PCES to Medicare or Medicaid. I have been informed that the nature and scope of treatment provided by FMPT does not qualify as a *covered service* for Medicare/Medicaid beneficiaries. I agree that FMPT or Ingrid Ratz, DPT, PCES may at its sole discretion, decline to treat my condition/diagnosis if the recommended nature of treatment may qualify as a *covered service* [i.e., Medically necessary] and may be potentially reimbursable by the Centers for Medicare/Medicaid. In that situation, FMPT may, but is not obligated to, make a referral to a physical therapist who accepts Medicare/Medicaid. I agree that I will disclose to FMPT if I am a beneficiary of Medicaid/Medicare in advance of receiving any treatment.

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1. **Virtual and In-Person Sessions**: I may elect to participate in Physical Therapy or Fitness Training either in person or through a remote platform such as ZOOM. I acknowledge that the same fee of $150.00-$185 will be charged for each session irrespective of the delivery method. If for any reason, in person sessions become a public health risk to either me or FMPT/Ingrid Ratz, DPT, PCES, I will be given the opportunity to discontinue sessions with 24-hours’ notice of cancellation for any scheduled sessions.
2. **At-Home Sessions**: I may elect, given availability, to schedule an at-home session which will be billed at a rate of $300.00 inclusive of travel time and gas. The at-home sessions are scheduled for 45 minutes. Upon arrival by FMPT/Ingrid Ratz DPT, PCES, I agree to be available and ready to begin treatment. If I am not ready, I understand that the length of the session will be shortened to finish at the scheduled time. If for any reason, at home sessions become a health risk to either me or FMPT/Ingrid Ratz, DPT, PCES, I or FMPT may discontinue sessions with 24-hours’ notice of cancellation to the other party.
3. **Attestation:** I certify to the best of my knowledge, information and belief that the above information is accurate and true. I have disclosed all medical conditions that I am aware of and will inform my practitioner of any changes in my physical or mental status. I understand that these services are a health aid and not a substitute for a doctor’s care. I also acknowledge that no guarantees or expected outcomes have been promised by FMPT nor have I relied on any outside material regarding physical therapy or fitness training that has led to an expected outcome, warranty or guarantee. I hereby sign this Financial Policy voluntarily and after reading it fully and carefully.

Patient Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is **under 18 years old**, the guardian/parent signing authorizes treatment of this client:

Guardian/Parent Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Parent signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_