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 Champaign, IL 61820
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METTLER THERAPY SERVICES POLICY ON FEES AND INSURANCE CLAIMS

I authorize treatment to be rendered, and assume financial responsibility for all charges related to treatment/therapy. I realize that professional services are rendered to me and not my insurance company. I understand that it is my responsibility to be aware of the type of insurance coverage I carry, and how much, if any, of the charges for therapy will be covered by my insurance policy or that of the responsible party. I understand that I am financially responsible for all charges for services to me including the balance remaining after payment of possible insurance benefits. I am aware that insurance companies may not always pay charges as billed, and that I am responsible to pay the Mettler Center for all charges that are not paid by my insurance or that of the responsible party.

This office cannot render services on the assumption that the charges will be paid by an insurance company. Therefore, in some cases Mettler Center physical therapy reserves the right to require payment directly from the patient at the time of service. In that case, we will submit charges to the insurance company and any reimbursement will go to the patient either directly from insurance or from reimbursement by our office. I understand that, upon approval, I may be able to make payment installments to fulfill my financial obligation (complete "Payment Contract" form).

Unless other financial arrangements have been approved by the "Payment Contract," I hereby agree to pay a finance charge of 1.5% per month (18% per annum) on all unpaid balances commencing 60 days from the service date. In addition, I agree to pay all reasonable costs you incur to collect this debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. This provision also shall apply if I file a petition or any other claim for relief under any bankruptcy rule of law of the United States, or if such petition or other claim for relief is filed against me by another. I also authorize the release of any medical information necessary to process this claim. I have reviewed and understand the fee schedule and any questions that I have in regard to the charges for therapy at the Mettler Center have been answered to my satisfaction.

Signature of Patient: _____
(signature of parent or guardian if under 18 years old)

Date: ____/____/____

CONSENT AND AGREEMENT TO COMPLY WITH PHYSICAL THERAPY

Your rehabilitation program is an ongoing process that requires regular attendance to be effective. If you do not attend our scheduled sessions, you are hindering your progress. If you must cancel, please call 24 hours before your scheduled appointment. If you fail to cancel and do not show up for an appointment, we count that as a "FAILED APPOINTMENT OR LATE CANCELLATIONS." In this case, there will be a \$50.00 charge (\$100 for patients receiving therapy at the Chicago office) that must be paid by the patient before physical therapy may be resumed.

We document each Failed Appointment, etc. If two occur, your physician and insurance carrier will be notified of your failure to attend scheduled appointments. This may have some effect on your disability status and/or disability benefits. In addition, your therapy will be discontinued until you get a new prescription from your referring physician.

Any attempt to exercise on any equipment or adjusting the equipment without prior instruction or without the knowledge of the primary physical therapist is done at your own risk. By presenting yourself for physical therapy treatments at this facility, you are consenting to the diagnostic procedures and care provided by the attending physical therapist and assistants. You have the right to refuse any drugs, treatments or procedures to the extent permitted by law. You acknowledge that because medicine is not an exact science, no guarantees or warranties can be made to you regarding the results of any treatment at this facility. Further, you understand that information from your medical record(s), kept by this facility, may be used for educational, research, administrative and/or facility approved purposes and your personal identity will not be revealed.

The physical therapy staff and assistants at the Mettler Center reserve the right to discontinue therapy at any time. Your signature is required before therapy commences and is an indication that you have read and fully understand the above general consent form and any questions have been answered to your satisfaction.

Signature of Patient: _____
(signature of parent or guardian if under 18 years old)

Date: ____/____/____