District
Physical Therapy
Rachel Sandhu, DPT

District PT Policies: Please sign below after carefully reading our policies. We are committed to providing you quality service and care and making clear our guidelines:

1. **Insurance:** We are a cashed based clinic and do not provide insurance coverage. Payment is expected when services are rendered. Patient is responsible for payment regardless of any possible out of network benefits. We can provide an invoice with ICD 10 coding if PT services were necessary and applied to visit. Patient can pay with credit card or debit card and check. There is a $50.00 fee for all returned checks. There will be $50 late fee if any bill from services rendered remains unpaid over 30 days past last appointment.
2. **Cancellations/No show**: If patient fails to cancel within 24 hours of his/her appointment, that patient will be charged in FULL for the amount of the visit missed and will not be reimbursed. If a patient is more than 15 minutes late, District PT may cancel or reschedule the appointment and client will still be subject to full session fee.
3. **Medicare**: We do not accept Medicare plans. We are not a Medicare provider and do not submit any claims.
4. **Durable Medical Equipment and Supplies:** Patient is responsible for all supplies and equipment provided.
5. **Triage**: When District PT deems medically necessary, clients may be triaged and referred to emergency services.
6. **Fees**: District PT may increase fees without notice however patient will be aware on website of current fee and should check before appointment time.
7. **Consent for Treatment**: Patient consents to the therapist at District Physical Therapy providing evaluation and treatment to patient as medically necessary.
8. **Medical Information Privacy**: We will make every effort to protect and keep your patient medical history private. This includes written correspondence with other medical providers and/or insurance companies via private fax, e-mail or USPS. You may also request any of your medical records with us by requesting in writing to Rachel Sandhu, DPT or District Physical Therapy.
9. **HIPPAA Compliance:** We need this record to provide you with quality care and to comply with certain legal requirements. Written correspondence with other medical providers and/or insurance companies is performed via confidential fax, e-mail, or USPS. Patient information with additional documentation will be kept in a locked file cabinet only available to appropriate therapist treating patient. Medical information will only be released to a third party upon authorization of the parent or guardian. If there is a failure to pay for the PT services you owe to Rachel Sandhu or other therapists at District Physical Therapy, this may result in a delinquency notice and if payment not received, your account may be turned over to a collection agency.

10. **If the patient is a minor under 18 years old receiving treatment:** Parent(s) signature for authorization are required and allow Rachel Sandhu, DPT or physical therapists at District Physical Therapy to perform physical therapy treatments with the patient who is a minor. The parent(s) also accepts full financial responsibility for the treatment.

Signature: _____ Date: _____
Parent's Signature: _____ Date: _____
(If client is under 18 years) Notice of Privacy Practices District Physical Therapy.
_____ (If client is under 18 years)

District Physical Therapy
Rachel Sandhu, DPT

Release of Information

I hereby authorize Rachel Sandhu, DPT or District Physical Therapy to release all medical information necessary to secure payment by phone or in writing, or for utilization and quality review purposes.

Patient or Guardian	Date _____ / _____ / _____

Financial Policy Statement

District Physical Therapy does not accept any insurance and requires full payment for physical therapy services. All patients are required to pay at the time of service and will be given a bill which is appropriate to submit for reimbursement to your insurance company. We are considered “out-of-network” providers for most insurance carriers except Medicare. We are not Medicare providers.

I understand and accept that District Physical therapy does not participate with or accept payment from any insurance company, is not a Medicare provider and does not accept Worker’s Compensation cases and does not accept cases where payment is contingent on law suit settlement.

Patient or Guardian	Date _____ / _____ / _____

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Rachel Sandhu, DPT or District Physical Therapy physical therapists furnish physical therapy care to _____, which is considered medically necessary in the diagnosis and treatment of the prescribed condition.

Patient or Guardian	Date _____ / _____ / _____

24 Hour Cancellation Policy & HIPAA Compliance

District Physical Therapy is committed to valuing patient care and access to treatment. We therefore require scheduled appointments to be cancelled within 24 hours. If you fail to cancel your appointment within the 24 hour time frame, you will be charged for the full session fee. Your cooperation is very much appreciated. I have also reviewed & understand the HIPAA compliance procedures for District PT.

Patient or Guardian	Date _____ / _____ / _____