Office Policies and Patient Authorization

Prescription

The District of Columbia does NOT require a prescription for treatment as we have Direct Access. However, if your insurance requires a prescription for coverage and payment, it is **your responsibility** to provide a written prescription during your initial evaluation. Medicare patients are **required** by law to have a new prescription and a signed plan of care (POC) by your physician every 90 days. Medicare patients will not be seen unless there is an active an updated POC.

Appointments

All appointments are scheduled one-on-one with a licensed physical therapist for up to an hour. Pure Sports Physical Therapy is dedicated to providing the highest quality of care so we expect all patients to be on time for every appointment. If a patient is more than 15 minutes late to an appointment we reserve the right to cancel the appointment. If you are unable to keep an appointment, we require at least 24 hours notice**. All appointments that are cancelled with less than 24 hours notice or no show appointments will be charged $75, which is not reimbursable to the insurance company.**

Billing and Payment

As a courtesy, Pure Sports Physical Therapy will submit and file claims with your primary insurance carrier, however, **all charges remain your responsibility on the date the service is rendered.** We are an out-of-network provider, which means that you are responsible for all deductibles and costs that are not covered by insurance. It is your responsibility to follow up with your insurance company after submission of claims to ensure proper claim processing. You are financially responsible for all rendered services and all incurred charges. In the event that collection procedures are required to collect an outstanding balance, you are responsible for costs of the collection agency, attorney and/or court fees.

Acknowledgement

I have read and understood the above polices and agree to abide by their terms. I authorize Pure Sports Physical Therapy to use my protected medical records for submission of claims to my primary insurance. In addition, I agree that I am held personally responsible for all charges that are not covered by my insurance.

Patient name_____Date_____

Signature of patient or Legal Guardian_____