GRANITE POINT
SANDPOINT, ID & ATHOL, ID

Patient Billing Policy

Sandpoint Physical Therapy, PC (DBA Granite Point Physical Therapy and Aquatics and/or Granite Point Physical Therapy and Wellness) sends a statement of account to our patients if there is a patient balance due. Any charges incurred for treatment will be billed to the insurance company that the patient provides to this office. We bill the insurance carrier first and if there is a patient balance due after we receive payment from your insurance company and after applying any private payments made to your account then a statement will be generated and emailed to the patient. In the event an email is not available or is undeliverable then a paper statement will be mailed to the patient. If there is no patient balance due then a statement is not generated.

Financial Policy

I, _____, being the patient at Sandpoint Physical Therapy, PC, (DBA Granite Point Physical Therapy and Aquatics and/or Granite Point Physical Therapy and Wellness) understand that I am fully responsible for any charges incurred during my physical or occupational therapy treatments. Any charges incurred for treatment will be billed to the insurance company that I provide to this office. If after 90 days the insurance company denies any bills for any reason or a settlement agreement has not been reached, full financial responsibility will be transferred to me. Thus, I will be expected to pay the balance on my account in full. It is my responsibility to contact Sandpoint Physical Therapy, PC if the obligation cannot be met. Applications are available for persons facing financial hardship. Sandpoint Physical Therapy, PC is committed to assisting our patients in meeting their financial responsibility however if arrangements are not made we will utilize the services of a credit bureau or a collection agency.

I understand and agree to the above Financial Policy and patient billing policy including receiving account statements via email.

_____ _____ _____

Person Responsible For Account **Relationship** **Date**

Email address for statements to be sent to: _____

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from Third-Party Payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices* and the Health Insurance Portability & Accountability Act (HIPAA).

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____ _____

Person Responsible For Account **Relationship** **Date**

Consent for Care and Treatment

I, _____ (patient name) give permission for Sandpoint Physical Therapy, PC (DBA: Granite Point Physical Therapy and Aquatics and Granite Point Physical Therapy and Wellness) to give me medical care and treatment.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient OR Guardian Signature:_____ Date:_____