



2026 Physical Therapy Patient Acknowledgement, Consent & Policy Agreement

GENERAL AGREEMENT AND EMERGENCY MEDICAL TREATMENT CONSENT

General Agreement

I hereby authorize Apex Physical Therapy and Wellness Center to provide treatment that will be discussed with me and agreed upon by both parties following the initial visit or authorized by my physician.

I hereby assign all insurance benefits (or services render to which I am entitled) to Apex Physical Therapy and Wellness Center. I realize that if my third-party payer/insurance company denies my charges or makes partial payment, that I am responsible for the balance

I hereby authorize the release of medical records and other pertinent information regarding safe and effective treatment of my condition to Apex Physical Therapy and Wellness Center for the provision of care and for obtaining insurance reimbursement

I hereby authorize Apex Physical Therapy and Wellness Center to contact the emergency contact I have listed on file if they feel I am unable to make safe and sound decisions.

I understand that I am legally responsible for payment to Apex Physical Therapy and Wellness Center for all services rendered. If my insurance is billed, I will be responsible for any remaining balance (co-insurance) and all co-payments/deductible amounts. I also acknowledge that all co-payments are due at the time of service. This does not apply to patients being treated under Worker's Compensation or Auto Insurance **Claims**.

Emergency Medical Treatment Consent

I understand and acknowledge that Apex Physical Therapy and Wellness Center and the EGYM at Apex are committed to ensuring my safety and well-being. In the event of a medical emergency during my treatment, I authorize the staff to take any necessary action in my best interest without delay. These actions may include, but are not limited to:

- Administering Cardiopulmonary Resuscitation (CPR)
- Utilizing an Automated External Defibrillator (AED)
- Wound Care/Controlling Bleeding
- Contacting Emergency Medical Services (EMS) for ambulance transportation
- Providing any other immediate and appropriate medical interventions deemed necessary by staff

I acknowledge that Apex Physical Therapy and Wellness Center and/or the EGYM at Apex may contact the emergency contact I have provided if, in their professional judgment, I am unable to make safe and sound decisions regarding my care.

I agree to hold harmless and release Apex Physical Therapy and Welles Center and the EGYM at APEX, its owners, employees, and contractors from any liability for acting in good faith while providing emergency medical treatment as described above.

I have read and understand the General Agreement and Emergency Medical Treatment and agree to abide by its guidelines:

Initials



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PAYMENT POLICY

- 1. Insurance.** We participate in most insurance plans. If you are insured by a plan we are contracted with and wish to submit to your insurance, a copy of your insurance card is required and must be up to date. **If you fail to provide us with the correct insurance information, you may be responsible for the balance of the claim.** The front desk will perform a verification of benefits with your insurance company. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to ensure accurate submission of claims. If your insurance company does not pay your claim, the balance will be billed to you.
- 3. Copayments.** All copayments are due and must be paid at the time of service. This arrangement is outlined in your contract with your insurance company and must be upheld by Apex in accordance with our obligations as a participating provider.
- 4. Claims submission.** We will submit claims to your insurance provider and make every reasonable effort to assist in the processing of your claims. However, your insurance company may require information directly from you, and it is your responsibility to respond to their requests. Please note that any remaining balance on your account is ultimately your responsibility, regardless of whether your insurance pays. Your insurance coverage is a contract between you and your insurance company; Apex is not a party to that agreement.
- 5. Non-covered services.** Please be aware that some services you receive may not be covered or considered medically necessary by Medicare or other insurance providers. While these services may still be submitted to your insurance, you are responsible for paying any charges not covered. Payment for non-covered services may be due at the time of your visit.
- 6. Cash for service.** We at Apex are committed to fair and reasonable fees. We have calculated a discounted Same Day Pay option that we offer if paid in full at each visit. I am aware that Apex Physical Therapy and Wellness Center will not submit any of my visits to my insurance based on my decision to waive that right. These arrangements must be made prior to your visit.
- 7. Nonpayment.** If your account is over 90 days past due, you will receive a phone call stating that you have 5 business days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If we are unable to reach you using the contact information we have on file, we reserve the right to reach out to any individual listed as an Authorized Contact or Emergency Contact solely for the purpose of obtaining an updated address or contact details. No personal health or financial information will be disclosed during this process unless prior authorization has been provided.
- 8. Missed appointments.** As a courtesy to our office, we ask that you please give us at least 24 hours' notice prior to cancelling or rescheduling an appointment. **If you do not call and notify our office that you cannot make your appointment, we will assess a \$50 "no-show" fee to your account.** These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges within our service area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

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MISCELLANEOUS POLICIES AND PROCEDURES

Marketing Communications Consent

By providing my contact information, including email and phone number, I consent to receiving marketing communications from Apex Physical Therapy and Wellness Center and/or the EGYM at Apex. These communications may include emails and text messages related to services, special offers, and updates.

We use a trusted third-party provider, Breakthrough, to manage and distribute these communications. Breakthrough may store limited demographic information (e.g., name and contact details) but does not have access to any personal health information. I understand that I may opt out of marketing communications at any time by contacting the clinic directly or using the unsubscribe instructions provided in the messages.

Use of Ambient Listening Devices for Documentation

I understand that treatment sessions may be recorded using the Athelas AIR electronic medical record system. The purpose of these recordings is to support accurate and efficient clinical documentation, thereby allowing the provider to focus more fully on one-on-one patient care.

All recordings will be encrypted, stored securely, and managed in compliance with HIPAA regulations. Recordings will be accessible only to authorized clinical staff and will not be used or shared for any other purpose.

I have read and understand the Miscellaneous Policies and Procedures and agree to abide by its guidelines:

Initials

Name of Patient: _____ Date: _____