C.O.R.E. Physical Therapy, PLLC
2440 M Street, NW, Suite 316
Washington, DC 20037

Office Policies & Patient Authorization

C.O.R.E. Physical Therapy, PLLC ("C.O.R.E.") is dedicated to providing highly individualized care for our patients with orthopedic injuries. Your plan of care is achieved through the professional assessment of your musculoskeletal system from your physical therapist. Your therapist will plan, implement, and monitor your treatment program.

PRESCRIPTIONS

The District of Columbia does not require a prescription for physical therapy 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 to have a new prescription** and a signed plan of care (POC) by your physician every 10 visits.

APPOINTMENTS

The initial evaluation will last approximately 60 minutes. All subsequent appointments will be scheduled for at least 30 minutes of 1 to 1 time with your physical therapist, but patients are usually in the office for 40-45 minutes for an appointment. If a patient is more than 15 minutes late for an appointment, we reserve the right to reschedule as there are no 15 minute appointments. In the event that you are unable to keep your appointment, we require at least 24-hours notice. **Appointments that are cancelled with less than 24 hours notice and no show appointments are subject to a $70 charge, which is not reimbursable by insurance companies.**

BILLING/PAYMENT

As a courtesy, C.O.R.E. Physical Therapy will submit and file claims with your primary insurance carrier on your behalf and your insurance company will reimburse you directly. However, **all charges remain your responsibility on the date the services are rendered**. It is your responsibility to ensure that the insurance company properly processes your claims. As an out-of-network provider, you are responsible for all costs that are not covered by insurance. O**ur relationship is with you, not your insurance company.** Patients are responsible for the full payment of charges at the time of service.

A signed consent form is required for the release of your medical records to parties other than you insurer with a fee charged for this service. In the event collection procedures are required to collect an outstanding account balance, the patient shall be responsible for the reasonable cost of a collection agency, attorney, and/or court costs.

ACKNOWLEDGEMENT

I have read and understood the above policies and agree to and abide by all of its terms. I authorize C.O.R.E. Physical Therapy to use my protected medical records for submission of claims to my primary insurance. In addition, I understand that I am personally responsible for all charges not covered by my insurance.

I, undersigned, grant consent for treatment of services provided by C.O.R.E. Physical Therapy.

______________________________________ ______________________________
Patient's Name Date

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Signature of Patient or Legal Guardian (if applicable)