REVOLUTION
REHABILITATION P.C.
PHYSICAL, ORTHOPEDIC & SPORTS THERAPY + WELLNESS

155 Printers Parkway, Suite 125 • Colorado Springs, CO 80910 • Office: 719-635-8622 • Fax: 719-635-8619

Welcome to Revolution Rehabilitation, PC.

We appreciate that you and your physician have chosen **Revolution Rehabilitation, P.C.** for your therapy needs. We offer highly skilled physical, aquatic and occupational therapy services with the goal of improving your function and status to achieve a healthy lifestyle. In return, we expect that you have the same commitment to your medical care and your financial responsibility associated with this care. As a courtesy, Revolution Rehabilitation will file your claim; however, it is your responsibility to know your insurance company's requirements. Any accounts not paid in full within 60 days of your first statement may be considered for collections and subject to applicable and legal fees.

SCHEDULING: Please schedule your appointments in advance and be sure to be prompt for your therapy sessions. This ensures that you will receive optimum time with your therapist. If you are unable to attend your scheduled appointment, we ask that you notify the clinic 24 hours in advance. Please reschedule any missed appointments in order to complete the number of visits per week as directed by your therapist\doctor. We are obligated to inform your insurance company, employer (if worker's compensation injury) and physician of your progress.

MEDICAL INSURANCE COVERAGE: Revolution Rehabilitation, P.C. Participates in most health plans, but not all.
As a courtesy we will contact your insurance carrier to verify your coverage. It is ultimately **your responsibility** to know your physical therapy coverage.

CO-PAYMENTS AND DEDUCTIBLES: As part of our contractual agreement with your insurance company we must collect these fees directly from you; the patient. Your annual deductible must be met before your insurance company will pay for your physical therapy treatments. Co-payments will be collected at each visit, please present co-payments upon your arrival. **Note:** *Verification of PT benefits is **NOT** a guarantee of payment. Please remember any changes made to your insurance policy may affect coverage and reimbursement rates. It is your responsibility to know your insurance benefits.*

WORKER'S COMPENSATION AND MOTOR VEHICLE ACCIDENTS: It is your responsibility to provide us with the name and address of the insurance carrier along with your claim number. We do NOT accept an attorney "letter of protection" for claims being disputed or in litigation but we can bill private insurance which your attorney can add to your case. ***If your auto claim is denied, for any reason, we will attempt to bill your private health care insurance, but understand you are ultimately responsible for payment in full.***

CANCELATION POLICY: Revolution Rehabilitation, P.C. A **24 hour notice** for the cancellation of a scheduled appointment is required. Failure to notify our office more than once will result in a **$35.00 charge to your account which is not covered by your insurance company**. If you feel ill, wary of road conditions or an emergency should arise contact us as soon as possible.

Note: Please use discretion when bringing children to your therapy session as this may be disruptive to your care and the care of others.
To restart your therapy, you must return to your physician for a new prescription and/or obtain authorization from your insurance.

Acknowledgement of HIPAA Privacy Practice and Consent to Treatment
I have read the copy of the Notice of Privacy Practice and Consent to treat. This Notice describes how my health information may be used or disclosed. I understand I should read it carefully. I was given the opportunity to review the Notice and ask questions regarding my privacy rights. **Initial_____**

Thank you for choosing **Revolution Rehabilitation, P.C.,** and we look forward to providing you with the highest standards of clinical care to assist you in attainment of your goals.
I have read and agreed to the above responsibilities.
Patient/ Guardian Signature: _____ Date: _____