

C.O.R.E. Physical Therapy, PLLC
2440 M Street, NW, Suite 322
Washington, DC 20037

Office Policies & Responsibilities

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 and physician. Your therapist will plan, implement and monitor your treatment program.

PRESCRIPTIONS

If required, you are responsible for providing C.O.R.E with a current written prescription on your initial visit to our clinic. **The District of Columbia does not require a prescription for physical therapy; however your insurance may require it for reimbursement. Medicare does require a new prescription** or signed treatment plan every 90 days for patients receiving therapy treatment.

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. Please arrive 5 minutes early for each 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 or no show appointments are subject to a \$40 charge, which is not reimbursable by insurance companies.**

BILLING/PAYMENT

Filing of primary insurance is a courtesy that we extend to our patients. C.O.R.E. will submit claims through our billing company (AMM), on your behalf, directly to your insurer (third party payer) whenever possible. All charges, however, remain your responsibility from the date services are rendered and it is your responsibility to ensure that the insurance company properly processes your claims. **As we are not participating providers with your insurance plan, our relationship is with you, not your insurance company.** Patients are responsible for the payment of charges not covered by their health benefit plan at the time of service, including any deductible.

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. Further, I understand that I am personally responsible for all charges not covered by my insurance.

Signature of Patient or Legal Guardian

Date

Patient's Name

Name of Legal Guardian (if applicable)

Relationship to Patient (if applicable)