Thank you for choosing Art Sansone PT LLC to provide your physical therapy and therapeutic massage therapy services. I strive to provide you with comprehensive, focused care through physical therapy consultations, manual therapy, therapeutic exercise and therapeutic massage.

Art Sansone PT

Appointment Information

Physical therapy consultations without treatment are approximately 40- minutes; initial consultations with treatment are normally 75-minutes; follow-up treatment sessions are approximately 30-60 minutes each; therapeutic massage sessions are approximately 50 or 80-minutes of direct “hands-on” treatment. Written medical and billing documentation for your physical therapy treatment will be completed during your session. Any further written documentation that is requested (i.e, medical evaluations, letters of ergonomic recommendations, exercise programs, etc.) will not be included within the duration of scheduled appointments and are subject to an additional fee.

Fees for Services

Consultation	$85.00/40-mins
Physical Therapy Treatments	$150.00/hr
Therapeutic/Wellness Massage	$90/60-mins;$130.00/90-mins
Additional written documentation	$25/15-mins

Fees are collected at the end of each appointment. I accept cash, checks, credit cards (MasterCard, VISA, American Express, Discover) and debit cards. An electronic receipt will be generated and sent to you within 3 business days of payment for your initial consultation. Follow-up appointment receipts are generated at the time of payment.

Cancellation/No-Show Policy

In the event that you are unable to keep a scheduled appointment, please contact me at 202-669-7044 or by email as soon as possible.

A cancellation fee will be assessed equal to the amount of your scheduled appointment for missed appointments and cancellations occurring without 24-hours notification prior to a scheduled appointment. Payment is required before

rescheduling or attending any subsequent appointments. This fee cannot be billed to insurance.

Please sign below to indicate you have read, understand and accept the terms of this late-notice cancellation/“no show” policy.

__________________ _______________
Your Initials Date

Inclement Weather policy

Cancellations occurring due to inclement weather follows the local government closure- if the city of Austin and/or West Lake Hills closes, no cancellation fee is required.

Billing Information and Insurance

I am licensed in Texas to provide physical therapy services. State laws for physical therapy practice in TX allows physical therapists to provide initial evaluations without a physician referral. However, TX law requires that any physical therapy treatment must be delivered under a medical prescription.

Art Sansone PT LLC does not a participate with any insurances. All fees associated with my services are your responsibility and will be collected from you at the time that services are rendered.

However, many insurance programs with “non-participating, out-of-network physical therapy benefits” will reimburse a portion of the total fee associated with the physical therapy services I provide. (Note: Medicare, Medicaid and insurances delivered through the health exchanges as part of the Patient Protection and Affordable Care Act will not reimburse any portion of services by non-participating providers). Your “non-participating, out-of-network physical therapy” are outlined in your insurance policy.

If you choose to bill your insurance company to reimburse your physical therapy costs, you are responsible for:

- verifying your “non-participating, out-of-network physical therapy benefits” with your insurance provider **prior** to submitting any claims for reimbursement.

- providing me with any information that your insurer requests that is not included in standard billing documentation.

- assuring that your insurance company properly processes all claims that you submit.

Please discuss with me any questions you may have prior to receiving physical therapy or to submitting documentation to receive physical therapy insurance benefits.

Acknowledgement

I have read, understood and agree to abide by the terms outlined above. Further, I understand that I am personally responsible for all charges that are not covered by my insurance provider.

Name (please print)____

Signed____Date______________________