*PhysioCare Physical Therapy*

*PLEASE READ CAREFULLY AND SIGN*

## Acknowledgement of Receipt of Privacy Practices Notice

I have been presented with a copy of PhysioCare Clinic's **Notice of Privacy Practices,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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## Financial Policy

*PhysioCare* will bill your insurance carrier as a courtesy to you. **However, you are ultimately responsible for payment for services you receive**. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance. If your insurance company does not cover physical therapy we apply a discount to your charges and require payment at the end of your appointment. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is made directly to you for services billed by us, you understand that you are obligated to remit the same to *PhysioCare*.

## Cancellation/ No Show Policy

The appointments made for you represent a time set aside specifically for you and your therapist. We value your time and ask that you value ours by giving at least 24 hours notice for any cancellations or changes to your appointment.

If your appointment is not kept, cancelled, and/or rescheduled **24 hours** prior to your scheduled appointment time you may be charged a **$40.00 fee**. This fee is not billable to insurance and is due at your next scheduled appointment. Patients who cancel or no show on two separate occasions without good cause will be allowed to schedule additional appointments only at the discretion of the treating therapist.

By law, all cancellations and no shows involving worker's compensation claims must be reported to your physician and claims adjuster.

## Co-pays

Co-pays are due at the time of each visit. It is your responsibility to know the amount of your co-pay. My co-pay is $__________.

My signature below acknowledges that I have reviewed, understand, and agree to the Notice of Privacy Practices, financial and co-pay policy and cancellation/ no show policy. By refusing to sign I understand that I, or my child, will not be able to receive care in this office.

| ______________________________ | ______________________________ | _______________ |
|---|---|---|
| Patient Signature | Parent/ Guardian Signature | Date |

*Rev 1.10*