PRACTICE POLICIES

AUTHORIZATION TO TREAT, RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Centralia/Chehalis Physical Therapy to evaluate and treat me (or my legal dependent). I authorize Centralia/Chehalis Physical Therapy to release to my insurance company(ies) any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at Centralia/Chehalis Physical Therapy. I hereby agree to full responsibility for all expenses incurred by myself, or minor child.

FINANCIAL POLICY AND AGREEMENT

* Insurance co-payments are required at check-in. We accept most major credit cards, cash and checks.
* Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and any changes to your insurance. Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claims. You are responsible for knowing what your insurance does or does not cover and the providers and network(s) covered by your insurance company. You will be billed for any service provided, but not covered by your insurance company.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

* I hereby acknowledge I have been offered a copy of the Notice of Privacy Practices/Privacy Rights to review.
* Other than my insurance companies and/or referring physician, ***other parties*** whom I give permission to obtain information on my behalf regarding my (or my dependent's): medical records, treatment, insurance, billing, appointment info include: ***may also be used as an Emergency contact, in the event of an Emergency**

Name:________________________________ Relationship:______________________ Phone:______________________

Name:________________________________ Relationship:______________________ Phone:______________________

LATE CANCELLATION/NO-SHOW POLICY

Please be advised, a minimum of 24 hours' notice is required if you need to cancel an appointment. Please help us serve all of our patients to the best of our ability by attending your scheduled appointments. When a scheduled appointment is not attended, it takes an available time slot away from another patient. No shows and late cancellations delay the delivery of services to other patients in need of physical therapy. If you no-show or cancel without sufficient notice, you may be charged a **$25 cancellation fee.** Patients who cancel with less than 24 hours' notice or do not show up for their scheduled appointment may also be placed on a flexible schedule. This means any scheduled appointments will be removed, but you are welcome to call in the morning to schedule an appointment that same day. We may not be able to accommodate all same day requests.

I HEREBY ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE PRACTICE POLICIES OUTLINED ABOVE:

X Signature: ____ **Date**: ________________