HANDS ON
PHYSICAL THERAPY, PC

Office Policies

Assignment of Benefits:

I hereby instruct and direct my insurance carrier to pay Hands On Physical Therapy for the professional medical expenses rendered and otherwise payable to me under my insurance policy. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Hands On Physical Therapy.

I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay any balance of said professional service charges over and above the insurance payment. I authorize the use of my signature in all insurance submissions pertaining to my treatments.

I HAVE READ AND UNDERSTAND THE ABOVE ASSIGNMENT OF BENEFITS.

Patient Signature:_____ Date:_____

Authorization for Release of Information:

I hereby authorize Hands On Physical Therapy to release my health care information including but not limited to testing, diagnosis, and/or treatment plans to my insurance company, adjuster, attorney, Worker's Compensation carrier, and/or to my referring physician or any physician that assists in the administration or continuation of my plan of care.

I hereby authorize any health care provider to release my personal health information as it pertains to my rehabilitative care if any is requested by Hands On Physical Therapy.

Patient Signature:_____ Date:_____

Appointment Cancellation Policy:

We request that you provide us with as much notice as possible when you need to cancel an appointment. This allows us to fill your slot with another patient that is in need of treatment (in some instances, this may be you).

If we are not given 24 hours notice (bad weather conditions exempt), we reserve the right to charge you $35 for that missed appointment. Please note that insurance companies will not reimburse for this charge. Also, if you have two no-show appointments, your Physical Therapist has the right to notify your doctor and terminate your Physical Therapy treatment program.

We appreciate your understanding and compliance with this policy. We have this policy in place so that we may provide Physical Therapy to all our patients who are in need. Thank you!

Patient Initials:_____

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