



Office Information Policy

Thank you for choosing Active Physical Therapy. We are committed to the success of your treatment with us. We believe that by being informed of our services and policies, you will be more successful. Please let us know if we can help you in any way.

Insurance: Benefits are verified prior to your first visit, but full reimbursement by your insurance company is not guaranteed. It is the patient's responsibility to understand the terms of his/her insurance coverage.

Private Pay/No Insurance: If you wish to be seen by us and not have us bill your insurance, or if you do not have insurance to cover our services, we ask for payment at the time of service with a 20% discount. If you use this option, please remember that we will not produce any formal billing form for your insurance. We will give you a copy of our daily fee slip that indicates what services were provided and what the charges were for that day.

Account Policies: Payment is expected in full at the time of service.

Returned Check Fee: A \$20 fee will be assessed for any checks returned without payment.

We Accept Cash and Checks

Cancellation Policy: We are committed to serving you and will do all that we can to accommodate your scheduling needs. In return, we ask that you call us at least 24 hours in advance if you need to re-schedule or cancel. This enables us to follow your treatment plan for a successful outcome. If you do not cancel within 24 hours there will be a \$60 charge to you, not reimbursable by your insurance. Three or more late cancellations or no shows will result in a full treatment charge.

Upon request, you will be provided with a copy of this form for your records.

By signing below you are:

- Accepting financial responsibility for your account.
Authorizing payment of any medical benefits from your insurance company to be sent directly to Active Physical Therapy.
- Authorizing the release of any medical information necessary to process this claim.
- Consenting to such treatment and patient care, which in the judgment of your therapist and/or physician may be considered necessary or advisable while a patient at Active Physical Therapy.

Regarding my request for Physical Therapy and my responsibilities, I have read the above, understand it, and agree to its terms.

_____ X _____
Date Signature of Patient or Responsible Party

Acknowledgment of Receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices from Active Physical Therapy.

_____ X _____
Date Signature of Patient

In lieu of patient signature, I, _____, a staff member of Active Physical Therapy, state that the patient has been given our current Notice of Privacy Practices. Date _____