



Cancellation Policy

Our number one priority is to help you improve your condition quickly and effectively. With the exception of a serious emergency, it is expected that you keep all your appointments so that we may service you to the highest level. If you need to reschedule an appointment, we require 12 hours notice. In such a case, please call our office and arrange for a make-up appointment with our front desk receptionist. The make-up appointment needs to be in the same week, preferably the very next day to help you receive the best results. ***In the instance of a cancellation without 12 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a \$25 fee.***

Insurance Referrals

If your insurance requires a referral from your Primary Care Physician, it is your responsibility to acquire that referral from your PCP. If your insurance company denies your visit due to the fact that a referral was not obtained, we reserve the right to bill you for that date of service. **Your insurance allows ____ visits per calendar year.**

Financial Policy

We will verify with your insurance carrier whether or not your insurance coverage indicates co-pays/coinsurances or a deductible. You are responsible for paying for services that fall under your deductible/coinsurance. All payments are due on the date of service.

Your estimated copayments/coinsurance will be: _____ Your deductible is: _____

Portion of deductible that has been met: _____

Understand that you are responsible for paying Elite Physical Therapy, Inc. directly for any applicable deductible/coinsurance/co-payment. This is a mandatory requirement when receiving healthcare services. Failure to meet your obligations is a violation of the agreement your insurance carrier and the carrier may take additional action. Please understand that if you have longstanding unpaid deductibles/coinsurance/co-payments, Elite Physical Therapy, Inc. will turn the account over to a collection agency.

In the event that insufficient funds are received, we reserve the right to charge you the bank penalty fee and a \$10 handling fee.

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits, to which I am entitled including Medicare, private insurances, and third party payers to Elite Physical Therapy, Inc. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment.

Consent for Treatment

I give my consent for Elite Physical Therapy, Inc. to provide me with medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

Acknowledgement of Terms & Notice of HIPPA

My signature indicates that I have been provided with a copy of the notice of privacy practices. I have read and understood the above policies.

Patient or guardian signature: _____ Date: _____

Witnessed by Elite Physical Therapy Staff: _____ Date: _____