Attendance Policy:
It is important that you make every attempt to keep your scheduled appointments. If you need to cancel an appointment, **please provide 24 hr. notice. Failure to do so will result in a $25 cancellation fee.** Attending every scheduled appointment is important in achieving your goals. This time has been reserved especially for you. If you cancel without 24 hour notice, then another patient has been denied that valuable space.

Financial Policy:
It is the patient's responsibility to verify insurance coverage for *out-patient physical therapy*. Our billing department will do verifications after the initial visit and submit claims monthly. Once we have received payment from your insurance company, a statement will be sent to the patient/guarantor indicating amounts of co-payments and/or deductibles not covered by your insurance.

We will wait up to 60 days from the date of submission for payment from the insurance company. If we have not received any insurance payment, we require the patients start making payments. Accounts past due (90+ days) can result in turning the account over to a collection agency.

In the case of a disputed *Worker's Compensation* or *Auto Accident* claim, we will bill the patient's health insurance company. If there is no health insurance, the patient is responsible for payment.

Some third party payers may reimburse at what they consider *Reasonable and Customary* charges. For large discrepancies, the patient is responsible for the difference; however, there is an appeal process that our billing department can assist you with.

In the event that the patient is left with a balance, payment is expected in full upon receipt of statement, unless other arrangements are made with the billing department.

Other Policies:

- I agree that Accelerated Mobility Physical Therapy,LLC, may release any medical or other information necessary to process my claim to my insurance companies.
- I authorize payment of insurance benefits to go directly to Accelerated Mobility Physical Therapy,LLC.
- I understand that I am responsible for verifying insurance coverage in an *outpatient physical therapy clinic.*
- I acknowledge that I have been given a copy of the Notice of Privacy Practices.
- I have read, understand and agree to the above policies.

Patient/Guardian signature _____________________________________Date__________