

ALLAIN PHYSICAL THERAPY & SPORTS REHAB LLC

Acknowledgement of Privacy Practices

I can request a copy of Allain Physical Therapy notice of privacy practices (or view on our website) which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability/Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Consent to Treatment /Release of Information

I, the undersigned, a patient at Allain Physical Therapy, do hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I authorize Allain Physical Therapy LLC to release any information during the course of my treatment including but not limited to medical records, verbal and written communications to my spouse, health providers, insurance company, employer, and third party payers.

____ YES ____ NO

I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that APT will prepare insurance forms, and will bill only as a courtesy to my insurance company directly. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Deductibles/Percentages pays and/or Co-payments:

Co-payments along with partial payment toward deductibles and coinsurance are to be paid at time of service. Payment for any remaining balance after the claims are processed is due at time of next visit or upon receipt of statement, whichever is sooner. All patients with an insurance deductible or co-insurance will be asked to make a pre-payment at each visit, which will be credited after claims are processed by insurance.

*** Cancellation/No-Show Policy (enforced) ***

Cancellations should be made at least 24 hours prior to my scheduled appointment. Our time is valuable too – if you do not show up for a scheduled appointment, or neglect to cancel **24 hours** prior to your appointment, you will be charged a **\$50 no-show/late cancel fee**.

Insurance Referrals

Patients are responsible to ensure referrals and authorizations required by insurance companies are obtained. As a courtesy, Allain Physical Therapy will assist the patient with this process. Patients will be held responsible for the cost of visits that are denied by insurance because a referral or authorization was not obtained.

By signing below, you are agreeing to acknowledgement of privacy practices along with all the terms and conditions listed above.

Printed Name: _____

Signature: _____ Date: _____