RESPONSIVE PHYSICAL THERAPY, INC.

AGREEMENT TO PAY FOR SERVICES RENDERED

We bill primary insurance only for your visits. We do not bill secondary insurance that is your responsibility. A statement will be provided for your convenience. It is understood and agreed that you will pay your portion of the bill (i.e. co-pay, co-insurance, deductible) when services are rendered. It is also agreed if insurance denies for any reason all charges will be your responsibility. It is also understood, that if for any reason (NSF check, etc.), costs (collection, attorney fees, court costs, etc.) incurred by Responsive Physical Therapy, Inc. to collect outstanding balance, plus accrued maximum interest allowed on balance over thirty (30) days, will be your responsibility and same will be added to your account balance for collection. **If a referral or prescription is required by your insurance, it is your responsibility to obtain one and bring it with you on your 1st visit. If you do not, all charges incurred will be your responsibility.**

LATENESS

Office policy requires that each patient arrive on time. Arriving late for an appointment impacts the schedule on all patients who follow. Please extend the courtesy to your fellow patients by arriving on time. If excessively late for an appointment, the treatment session will be at the discretion of the physical therapist.

CANCELLATION POLICY

1) Twenty-four (24) hours' notice must be given when an appointment cannot be kept. If twenty-four (24) hours' notice is not given, it is considered a No Show.

2) **Upon three (3) No Shows, the patient will be charged for the visit.** Please note that a necessary component of your physical therapy is keeping your scheduled appointments and upon three (3) No Shows, therapy will continue at the discretion of the treating therapist.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices and if a request is made will be given a copy of same.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Responsive Physical Therapy, Inc. to release any information to my physician, insurance company and when applicable, rehabilitation nurse and/or day care center during the course of my examination or treatment.

Signing below designates that I have read, understand, and agree to the above.

PATIENT'S SIGNATURE (IF A MINOR PARENT OR GUARDIAN MUST SIGN) DATE