Acknowledgement of Policies

The following are our office policies governing patient care. Please read carefully and initial each policy signifying your understanding and agreement to abide by said policies.

___**Appointment Scheduling**. We will strive to provide you with effective, efficient treatment and accommodate your needs to the best of our ability. To be fair to all of our patients, we ask that cancellations be made 24 hours in advance, and if you are going to be late for your appointment, please call and let us know. Adherence to the recommended plan of care and consistency with appointment attendance is vital to your progress. Please make every effort to follow this plan. Lastly, if you miss more then 3 appointments without prior notification, we reserve the right to discontinue your therapy to open the schedule to new patients. Thank you for your cooperation regarding these policies.

___**Consent to Treatment**. I voluntarily consent to physical therapy evaluation and treatment as prescribed by my attending physician or his/her designees as necessary, under the direction of a registered physical therapist/physical therapist assistant. Further, I acknowledge that no guarantee has been or can be made as to the results of such treatments.

___**Privacy Practices Acknowledgement**. We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the ***Health Insurance Portability and Accountability Act*** of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. By initialing this section, I, the undersigned, acknowledge that a copy of Cape Coastal PT***Notice of Privacy Practices for Protected Health Information*** has been made available to me.

___**Assignment of Benefits**. In consideration of agreement between Cape Coastal PT and myself to provide me with physical therapy services, I hereby irrevocably assign toCape Coastal PT my right, title, and monetary interests in, and to all, insurance benefits to which I may be entitled to. Assignment of such benefits is limited to the extent of the amount of the cost of all services to me by. I hereby authorize all payment for services provided by Cape Coastal PT \ to be paid directly to Cape Coastal PT that may be due upon receipt of claims or itemized statements for services ren

___**Billing/Information Release.** I authorize Cape Coastal PT to furnish all necessary parties any information it may have regarding my condition while under observation or treatment deemed necessary to facilitate reimbursement for services rendered. I acknowledge that Cape Coastal PT is duly authorized such rights in accordance with all federal and state confidentiality laws.

___**Responsibility of payment.** I, the undersigned, acknowledge full financial responsibility to Cape Coastal PT for any and all charges not covered by my insurance policy. This includes all co-pays, deductibles, or charges that are denied payment by my insurance company for services rendered.

I certify that I have read, understand, and agree to abide by all office policies listed above.

Patient Signature___________________________________ Date________________

Name (please print)_________________________________

Witness Signature __________________________________ Date________________

Name (please print)_________________________________