Acknowledgement of Head to Toe PT Office Policies

The following are Head to Toe Physical Therapy's policies governing appointment scheduling, payment terms.
***Please read carefully and initial after each section** before signing the bottom.*

Appointment Scheduling. We at Head to Toe Physical Therapy are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. This means that if you miss several appointments without notifying Head to Toe (emergencies considered), you may dismissed from care and your file may be closed. *We only treat those patients who want to get well!*

X________

Consent for Treatment. I, the undersigned, give Head to Toe Physical Therapy my permission to evaluate and treat my injury. I further understand that, in the course of recommended treatment, condition may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment.

X__________

Assignment of Payment. I hereby **authorize** my insurance company and/or my attorney to pay direct to Head to Toe Physical Therapy, PC any monies due on my account for professional services rendered. **X**__________

Acknowledgement and Understanding. It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office. **X**__________

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) **X**__________

Cancellation Policy. Please be advised that if you fail to give 24 hours notice to cancel an appointment you will be charged $20. Emergencies and sicknesses will be excused at the discretion of your therapist. We are unable to bill your insurance company for appointments that you miss and hope that you can respect that our time is valuable!

X__________

Patient HIPAA Consent Form. Our Notice of Patient Information Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

X__________

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature ____ **Date** __________________________

Name (please print) ____

Witness Signature ____ **Date** __________________________

Name (please print) ____