Patient Name: _____

Please **read** and **initial** indicating that you are aware of and will adhere to following policies:

_____**Authorization for Treatment**: I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Response Physical Therapy

_____**Appointment Policy**: I understand that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three consecutive appointments, Response Physical Therapy has the right to discharge me from care for being non-compliant with my treatment plan. I understand and agree that Response Physical Therapy requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $50 charge (which is not covered by insurance)

_____**Copays**: Copays are due at the time of service and will be collected at each visit

FINANCIAL POLICY AND INSURANCE INFORMATION
Please **read** the statement below and **sign** indicating understanding**:**

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment, if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt and Response Physical Therapy will bill my insurance company and refund me any monies received by them from my insurance company for said supplies.

I hereby give authorization for payment of insurance benefits to be made directly to Response Physical Therapy for services rendered. In the event that my insurance company forwards payment directly to me, instead of Response Physical Therapy, I will immediately deliver said payment to Response Physical Therapy.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for Response Physical Therapy to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

Signature: _____ Date: _____
Patient and /or parent or legal guardian

Relationship to patient, if patient is under 18 years of age: ☐ Mother ☐ Father ☐ Legal Guardian