TEWKSBURY PHYSICAL THERAPY

PLEASE READ THE FOLLOWING CAREFULLY
THEN SIGN AND DATE BELOW (Initial where indicated)

CANCELLATION AND NO SHOW POLICY

AFTER TWO "NO SHOWS", THE REMAINDER OF YOUR APPOINTMENTS WILL BE CANCELLED. 24 HOUR NOTICE IS REQUIRED FOR CANCELLATION, MULTIPLE CANCELLATIONS WILL RESULT IN TERMINATION OF THERAPY.

Initial: _____

INSURANCE REFERRALS/AUTHORIZATIONS

I understand that if I am a member of a health insurance company that requires referrals and or authorizations for physical therapy, that for each treatment for which I do not have a referral or authorization to been seen, I will be responsible for payment of services rendered should these treatments be denied by my health insurance carrier. Most insurance companies, including Medicare, have limited benefits. Please contact your insurance company for benefit details. You can also ask our staff for assistance in determining limits.

Initial: _____

NOTICE OF INFORMATION AND PRIVACY PRACTICES

I have been provided a copy of the Notice of Information and Privacy Practices. I understand my rights as a patient outlined in this document.

Initial: _____

ELIGIBILITY AND BENEFITS

It is the responsibility of the patient or responsible party to confirm their eligibility and benefits with their health carrier. You are responsible for contacting your insurance carrier to establish what your individual benefit is for services rendered. As a courtesy, Tewksbury Physical Therapy checks eligibility and benefits on all patients, however we cannot be held responsible for misquoted benefits.

Initial: _____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all services rendered by Tewksbury Physical Therapy to myself and/or my dependents. I understand that should my insurance company deny payment of treatment for any reason, I will be responsible for the charges. I further understand that I am financially responsible for, and agree to pay, all deductibles as well as any copays and/or co-insurances under my or my dependent's insurance plan. Copay payments will be collected upon arrival at each treatment.

Initial: _____

ASSIGNMENT OF BENEFITS

I hereby assign and authorize payment of all medical benefits directly to Louis B. Coiro, Inc., DBA Tewksbury Physical Therapy, which I or my dependents are entitled to, including Medicare and other government sponsored programs, private insurance and any other health plan including worker compensation and auto insurance carriers, for all charges incurred by me or my dependents.

Initial: _____

RELEASE OF INFORMATION

I hereby authorize Tewksbury Physical Therapy to release any and all medical records of myself or my dependents to my health insurance carrier, auto insurance carrier or worker compensation carrier, if necessary to secure payment of my claims.

Initial: _____

I HAVE READ AND UNDERSTAND THE ABOVE

PRINT NAME: _____

SIGNATURE: _____ DATE: _____