Finest
PHYSICAL THERAPY

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ATTENDANCE POLICY /PAYMENT POLICY/ASSIGNMENT OF BENEFITS

Here at Finest Physical Therapy we pride ourselves on providing the highest quality of care for you to obtain optimal results. Your success in Physical Therapy is a direct result of regular attendance in compliance with your treatment program recommended by your Physical Therapist, as well as following any home instructions during the course of your treatment. Due to our commitment to providing one on one individualized care it is important that we see patients in a timely manner.

1. We therefore require 24 hours notice for any cancellations. There may be a fee for cancellations made with less than 24 hours notice as follows:

1st cancellation: Fee waived, 2nd cancellation: $50.00, 3rd cancellation: $100.00

I, _____ have read and agree to the above terms and conditions

Patient or Guardian Signature:_____ Date: _____

2. Payment is due at time of service unless other arrangements have been made and approved in advance.

The "Usual and Customary" charges quoted by your insurance company are charges that have been determined by the insurance company and may not necessarily reflect our fees. Not all services are covered by all insurance companies, they may be selective.

"I also understand that should my insurance company send payment to me, I will forward the payment to Finest Physical Therapy, LLC within 30 days. I agree that if I fail to send my payment within the 3 day period, I understand that my account may be turned over to collections and that I will be responsible for any fees charged by the collection agency"

Patient or Guardian signature:_____Date:_____

3. Direct Assignment of my rights and benefits under this policy.

I hereby assign all medical benefits, including all major medical benefits to which I am entitled, including Medicare, private insurance, and other health care plans to Finest Physical Therapy, LLC. This payment will not exceed my indebtness to the above mentioned assignee and I have agreed to pay, incurrent manner, any balance of said professional services charged over and above this insurance payment. I understand that I am ultimately responsible for my physical therapy charges and I agree to pay any charges not reimbursed by my insurance company. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release of all information necessary to secure payment. I understand and agree that payment by the person responsible party will not be delayed or withheld because of any dispute between the reasonable party and any insurance company, reimbursing agency, third party payer or because of pending legal claims. I authorize the use of my signature on all insurance submissions

Patient or Guardian signature:_____Date:_____