

Amber Hill Physical Therapy

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for *Amber Hill Physical Therapy* to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian _____ Date ___/___/___

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including private insurance and any other health plans, to *Amber Hill Physical Therapy*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian _____ Date ___/___/___

Scheduling and Cancellation Policy

Amber Hill Physical Therapy reserves the right to bill a minimum \$35 no show fee for any appointment not canceled 24 hours in advance. Consistency in treatment is important to your rehabilitation outcome therefore multiple cancellations may result in termination of your treatment or a loss of prime (desired) schedule time.

If you are late for an appointment we may not be able to provide you with treatment as a courtesy to our other patients.

Patient/Guardian _____ Date ___/___/___

Financial Policy Statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when the services are rendered. A payment of your estimated share is required to be paid upon each visit. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If your carrier pays any funds in excess you will be refunded the credit. All patient balances over 60 days from date of transfer to patient responsibility, will be charged interest monthly at the rate of 10% annually. We reserve the right to discontinue treatment if no attempt to resolve large past due balances is made.