Patient Responsibility

While being treated at Amber Hill Physical Therapy, there may be the need to use certain products to improve your treatment. **As the patient, you are responsible for providing these items. (Exp. Theraband, Electrical Stimulation Pads, Hand therapy products such as Coban, Stretch bandages, TubiGrip, Stockinette or supplies used for Splints)** You may provide these items yourself or you may purchase them from AHPT at a reduced price. These items are not considered durable medical equipment and the cost will not be covered by your insurance company. You are responsible for the cost of any items purchased. AHPT will provide you with a receipt to submit to any Health Care Savings or Flex plans.

Patient or Responsible Party ___________________________________ Date___/___/___

Patient Agreement

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by *Amber Hill Physical Therapy*, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Estimated patient payment % ______________
(Estimated coverage information is provided as a courtesy, but is not intended to release the patient from total responsibility for the account balance.)

Patient or Responsible Party ___________________________________ Date___/___/___

AHPT Representative ____ Date___/___/___

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____, have received the Notice of Privacy Practices from Amber Hill Physical Therapy Inc. The notice is dated April 14, 2003.

Date: ________________

In lieu of patient signature, I, ____, a staff member of Amber Hill Physical Therapy Inc, state that
____

has been given our current Notice of Privacy Practices.

Date: ________________