essential
physical therapy & pilates

Name_____

DOB_____

## PLEASE CHECK THE BOXES BELOW AND SIGN:

- ❑ **Authorization for Treatment:** I hereby authorize Essential Physical Therapy & Pilates to implement a treatment program for me.

- ❑ **Cancellation Policy:** I acknowledge that Essential Physical Therapy & Pilates will require a $45 payment after two (2) missed appointments or cancellations with less than 24 hours notice. I realize payment will be necessary before I can return for follow-up appointments. Inclement weather and illness will not apply.

- ❑ **No-Show Policy:** I acknowledge that it is important to call if I am not able to be at my appointment. Patients who do not notify that they need to cancel will be considered "no shows." Two or more "no show" instances will result in inability to continue receiving treatment at this facility.

- ❑ **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notices of Privacy Practices for Essential Physical Therapy & Pilates.

- ❑ **Financial Policy –Commercial Insurance Companies:** As a participating provider for my insurance, Essential Physical Therapy & Pilates agrees to bill my insurer for services. I am responsible for any deductible, co-payment and co-insurance amounts, as well as any allowed balance not paid by my insurance company, which is therefore deemed my responsibility.

  It is imperative that I provide Essential Physical Therapy & Pilates with all insurance information, prior physical therapy and chiropractic visits, as well as any changes in my insurance prior to each visit. Failure to do so will result in my being responsible for any and all charges that Essential Physical Therapy & Pilates is unable to collect.

  I have read and agree to the high deductible policy.

- ❑ **Authorization for Rehabilitation Services for Medicare Beneficiaries:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release into the Social Security Administration or its intermediaries or carriers of any information needed for this or related Medicare Claim.

  I agree to pay my annual deductible and co-insurance amounts not reimbursed for services rendered.

- ❑ **I request that payment of authorized benefits be made on my behalf to Essential Physical Therapy & Pilates.**

- ❑ **I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to Essential Physical Therapy & Pilates for myself and /or dependents.**

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Signature of Patient/Guardian Date