

**PATIENT AGREEMENT**

* Physical therapy is by physician referral and appointment only.
* If a patient is more than 15 minutes late for an appointment, **Physical Therapy Fit For Life** reserves the right to cancel the  appointment and charge a $50 late cancellation fee.
* A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, OR THE**  **PATIENT WILL BE CHARGED** a $50.00 late cancellation fee.
* **A late cancellation may be rescheduled TO AVOID THE CANCELLATION FEE** if the appointment is rescheduled within the same Monday – Friday period (prior to the upcoming weekend). In other words, if a patient begins the week with two appointments and completes the week having had two treatments, no cancellation charges will be assessed if one appointment had been late cancelled and rescheduled.
* At the end of each week**, ALL PATIENTS** including those eligible for No-Fault, Worker’s Compensation, Medicare or any other insurance coverage, **WILL BE DIRECTLY RESPONSIBLE FOR PAYMENT OF $50.00 FOR EACH MISSED OR LATE-CANCELLED (non-rescheduled) APPOINTMENT.**
* Should a patient miss two consecutive appointments without calling to cancel, the patient will be taken off the master schedule and will forfeit all further permanent appointments.
* If a patient does not honor a rescheduled appointment, THE PATIENT WILL BE CHARGED FOR BOTH THE ORIGINAL CANCELLATION AND THE RESCHEDULED APPOINTMENT.
* **PLEASE INFORM THE FRONT DESK STAFF OF ALL SCHEDULING CHANGES. YOUR THERAPIST IS NOT RESPONSIBLE FOR YOUR SCHEDULE**.
* Full payment of your outstanding deductible and all initial co-payments are to be made directly to PHYSICAL THERAPY FIT FOR LIFE at the time of the initial visit. Subsequent physical therapy co-payments (and cancellation fees assessed) are to be made at the time of each visit.
* If any changes are made to patient insurance/payment coverage, patient agrees to alert Physical Therapy Fit For Life as soon as possible to these changes.  \_\_\_\_\_\_ I understand that I will pay all treatment fees directly to PHYSICAL THERAPY FIT FOR LIFE. \_\_\_\_\_\_ I understand that I am responsible for my deductible, co-pays and all late cancellation or no-show fees. \_\_\_\_\_\_ I hereby state that I am not eligible for NY No-Fault, NY Worker’s Compensation or Medicare. I agree to treatment on the above terms. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_