SPRINGFIELD
PHYSICAL THERAPY

Springfield Physical Therapy
2221 Grube Street
Springfield, OH 45503
Phone: 937-399-8941 Fax: 937-399-5639

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Patient: _____

I, _____ hereby acknowledge that I have reviewed The Notice of Privacy Practices and may be provided a copy upon request.

Signature: _____

Relationship to Patient (if patient is a minor): _____

Date: _____

BILLING POLICY, RELEASE AND AUTHORIZATION

I authorize Springfield Physical Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Springfield Physical Therapy. I authorize Springfield Physical Therapy to release medical or other information necessary to process this claim. I understand I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

Signature: _____

Date: _____

APPOINTMENT CANCELLATION FEE

The Staff of Springfield Physical Therapy is committed to improving its facilities and service provided to you. As a result, it is has become necessary to implement a $25.00 late appointment cancellation fee for any scheduled appointments that are not cancelled within 24 hours, or for NO SHOWS.

Your cooperation is greatly appreciated. Thank you, Springfield Physical Therapy

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

Signature: _____

Date: _____