



**ALLIED PHYSICAL THERAPY**

**128 Middle Street, Farmington, Maine 04938**

**207-778-6469**

**FAX 207-778-3486**

**PLEASE READ AND INITIAL ALL POINTS BELOW**

\_\_\_\_ I understand and agree that if I need to cancel/change an appointment, I will give at least 24 hour notice or, if ill, I will call by 8AM the day of my appointment. If we are unavailable, you may leave a message on our answering machine.

\_\_\_\_ We reserve the right to charge \$36.00 if you miss your appointment without the proper notification.

\_\_\_\_ Also, Allied Physical Therapy reserves the right to discontinue treatment of a patient with a history of broken or missed appointments.

\_\_\_\_ I will notify Allied Physical Therapy of any changes on this form, the Registration Form, Insurance status, or on my Medical Intake Form.

\_\_\_\_ I understand my physical therapy benefits, including any limitations, of my insurance plan.

**FINANCIAL POLICY STATEMENT**

\_\_\_\_ I understand that insurance co-pays, co-insurance, and deductibles are due at each visit. If I do not have insurance, I understand payment is due in full at the time of appointment.

\_\_\_\_ I understand and agree that I am ultimately responsible for the balance on my account for professional services rendered by Allied Physical Therapy. I understand that I am financially responsible in the event that all or some payment is denied or not covered by my insurance carrier(s) or other third parties that are responsible for payment.

\_\_\_\_ I request that payment of authorized benefits be made on my behalf to Allied Physical Therapy. If this claim is paid to the patient instead of the provider, I agree to endorse the check to Allied Physical Therapy or send payment directly to Allied Physical Therapy within the same day of receiving payment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

**ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"**

\_\_\_\_ I understand that I can request a copy of the Notice of Privacy Practices at Allied Physical Therapy. The notice is posted at Allied Physical Therapy and I can inquire about the practice's Notice of Privacy Practices at the front desk.

**PATIENT ACKNOWLEDGEMENT**

I HAVE READ AND UNDERSTAND THE Financial Policy Statement, Consent for Care and Treatment, Release of Records, and Notice of Privacy Practices, as set forth above. I consent and agree to all the terms and conditions as set forth in these documents.

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**(PARENT IF MINOR)**

**PRINTED NAME** \_\_\_\_\_