ANDERSONVILLE
PHYSICAL THERAPY

CONSENT AND FINANCIAL RESPONSIBILITY AGREEMENT

1. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand that it is important that I keep my prescribed appointments and arrive on time to all of my appointments in order to get the maximum benefit from my physical therapy program. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment. **I understand that if I cancel an appointment with less than 24 hours' notice or do not show up for a scheduled appointment, I will be charged $40.**

2. **RESPONSIBILITY FOR PAYMENT:** All copays are due at the time of service. I acknowledge that in consideration of the services provided to me by Andersonville Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Andersonville Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, copays, co-insurance or charges not covered by my health insurance, Medicare or other programs for which I am eligible. **Please note that refusal to sign this form does not change responsibility for payment in any way.**

3. **PAYMENT AUTHORIZATION AGREEMENT:** I hereby authorize Andersonville Physical Therapy to keep the my credit card information on file for payment of **late cancellation/no-show fees**. This credit card information will be stored on a PCI and HIPAA-compliant website. I understand that this credit card will not be used for any bills or charges other than late cancellation/no-show fees, unless I authorize Andersonville Physical Therapy to do so. I agree to notify Andersonville Physical Therapy if any of this account information changes.

4. **HIPAA CONSENTS:** In compliance with HIPAA regulations, I consent to the following information regarding my treatment or the billing of my account (please include family members or friends who will be attending appointments with you):

_____ NAME/RELATIONSHIP

_____ NAME/RELATIONSHIP

I also authorize the release of appointment information left in a voicemail, answering machine or email and understand that there is some level of privacy risk associated with these forms of communication. I also acknowledge that I have received the Notice of Privacy Practices and have been provided with an opportunity to review it.

By signing below, I certify that I have read, understand and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____ SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____ DATE

Andersonville Physical Therapy does not discriminate on the basis of race, ethnicity, age, disability, gender identity or sexual orientation.