LEISURE PHYSICAL THERAPY CONSENT FORM

PATIENT NAME:_____

Welcome to Leisure Physical Therapy, P.C. As a courtesy, we will try to get the most accurate information regarding your physical therapy benefits; however, we may not be given complete or proper information. It is your responsibility to educate yourself about the physical therapy benefits and limits available to you according to your policy as well as any financial responsibility required of you for our services. **AT TIMES THE INSURANCE COMPANY GIVES US WRONG INFORMATION. YOU ARE STILL RESPONSIBLE FOR PAYMENT.**

It is also your responsibility to make our office aware when you change your insurance carrier and/or insurance policy; as well as gain or drop a secondary/supplement insurance. Any services provided that are denied due to no insurance coverage will be your full financial responsibility and will be billed accordingly.

CANCELLATION POLICY

We require 24 hour notice in the event of a cancellation. We reserve the right to charge a **$10** fee to those who fail to cancel without a 24 hour notice. If you reschedule during the week you will not be charged.

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement of Receipt of Notice
This is to acknowledge that I have received and reviewed Leisure Physical Therapy P.C. Notice of Privacy Practices. Should I have any questions regarding the Notice of Privacy Practices I understand that I can contact Leisure Physical Therapy at **631.821.8090**

I hereby authorize **Leisure Physical Therapy** to furnish information to my insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. In the event that the provider's charges are outstanding or I fail to provide the office with the insurance information, I understand that I am personally responsible for payment of the provider's charges.

By signing I agree to the above:

SIGNATURE OF PATIENT:_____ DATE:_____