POLICY & GUIDELINES

- **Please carefully read each statement and initial, verifying that you understand all of the information.**

PATIENT CANCELLATION / NO SHOW AGREEMENT

Initial: _____

In order to comply with your plan of care, set by your physical therapist, a 24 hour notice is required for all patients cancelling or rescheduling office visits. If a 24 hour notice is not given for the missed appointment, a $30 fee will be assessed at your next visit. The $30 fee will be waived if another appointment is scheduled to substitute the missed appointment. (This appointment must be a new appointment and not one already scheduled for the week).

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Initial: _____

I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault. I assign to Performance Rehabilitation all benefit payments for services rendered under the terms of the insurance policies and obligate the payer to pay the account to Performance Rehabilitation in accordance to the usual and customary charges incurred during my course of treatment.

CONSENT FOR EVALUATION AND TREATMENT

Initial: _____

I authorize Performance Rehabilitation and its designated staff to perform a physical therapy evaluation and any course of treatment deemed necessary by the therapist and/or the referring physician.

WORKER'S COMPENSATION PATIENTS

Initial: _____

Performance Rehabilitation will notify your manager and or case manager of any missed or cancelled appointments that are not rescheduled for the same week.

AUTHORIZATION TO RELEASE INFORMATION

Initial: _____

I authorize Performance Rehabilitation to release any and all information regarding my evaluation, care, and treatment to my insurance company, third party payer, and/or employer (work related injury). Your health information will be used and disclosed to provide your care and treatment, to bill and collect payment for services rendered, and to communicate with insurance companies, third party administrators, utilization review organizations, and healthcare service plans. You have the right to request that we restrict how your health information is used or disclosed. You have been given time to review the "Notice of Privacy Practices" that contains a complete description of the uses and disclosures covered under this consent. You may also review this notice on the company website at www.performancerehabnc.com.

By signing this authorization form, I understand all of the above statements. I have been given time to ask questions and they have been answered satisfactorily.

_____ _____

SIGNATURE (PATIENT, PARENT, RESPONSIBLE PARTY) **DATE**