Goffstown PHYSICAL THERAPY & Rehabilitation Associates

Patient Responsibility

I understand that I am responsible for knowing my insurance benefit for physical therapy and any limitations therein. Additionally, I understand that I may be billed for any service or product provided by Goffstown Physical Therapy that has not been covered by my insurance. This may include, but is not limited to, co-payments, coinsurance, deductibles, or any non-covered services. I understand if I do not pay my balance, Goffstown Physical Therapy has the right to send the balance to a collection agency.

I give my permission to Goffstown Physical Therapy to release medical information to my physician, insurance company, and/or attorney.

Initial here_____

I authorize release of payment to Goffstown Physical Therapy for professional services rendered.

Initial here _____

I have reviewed the Goffstown Physical Therapy Notice of Privacy Provisions and understand my rights to the privacy of my health information.

Initial here _____

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Name of Patient **Relationship to Patient**

Cancellation Policy:

This letter is to inform you of our cancellation / reschedule policy. We require 24-hour notice if you cannot keep a scheduled appointment.

If you cancel or reschedule less than 24 hours before your appointment, or miss it all together, there will be a charge of $30.00. This fee is due at your next visit. This charge is to cover expenses incurred by our office because of your missed appointment as we have other patients we need to schedule.

This amount is owed by you, and cannot be billed to your insurance company. In the event we are able to fill your appointment with another patient, the fee will be waived.

Thank you for your cooperation in this matter.

I understand that if I must cancel or reschedule my appointment, I am responsible for contacting Goffstown Physical Therapy within 24 hours of that visit.

_____ _____

Signature of Patient or Guardian **Date**