HIGHLINE
PHYSICAL THERAPY

Patient Name: _____

It is very important for your recovery that you attend all your scheduled therapy treatments. ***WE REQUIRE 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT.*** *A $40.00 fee may apply after a missed appointment if proper notice is not given*.*

MISSED APPOINTMENT POLICY

- *If you fail to show or cancel 2 appointments, all remaining appointments may be removed from the schedule. _____ Patient Initials*
    - *If you wish to continue with your therapy, then you must call the day of to schedule an appointment. You may also choose to pay a $40.00 fee to resume advanced scheduling. _____ Patient Initials*

** Massage Therapy Clients: $40.00 missed appointment fee will apply after the second missed appointment. _____ Patient Initials*

CO-PAYS

If your insurance has a co-pay, it is due at the time of service. The fee for billing outstanding co-pay(s) is $30.00.

TERMS OF PAYMENT

A claim will be submitted to your insurance company on your behalf. Your portion of your bill is due within 10 days of receipt of HPT statement. A re-billing charge of 1% per month is added to account balances over 60 days.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Highline Therapy Services' Notice of Privacy Practices that describes how my health information is used and shared. I understand HTS has the right to change this Notice at any time. I may obtain a current copy by contacting the clinic or the billing office.

HPT has my authorization to release billing information and/or condition information to:

- ❒ Myself and my insurance carrier
- ❒ My Spouse
- ❒ My immediate family
- ❒ My employer
- ❒ Other: _____

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices and that I have authorized Highline Physical Therapy to discuss my billing information and/or condition with the people above.

RELEASE OF BENEFITS AND INFORMATION

I authorize my insurance benefits to be paid directly to Highline Physical Therapy (HPT). I am responsible for all co-payments, deductibles, and non-covered services as determined by my insurance plan at the time of claims processing. I have read HPT's billing policy. I authorize HPT or my insurance company to release any information required for processing of this claim per HPT's Notice of Privacy Practices. I consent to receive treatment as prescribed by my doctor. A copy of this authorization shall be as valid as the original.

_____ _____

Signature of Patient or Guardian Today's Date

IMPORTANT NOTICE: *We strongly recommend you call your insurance company to verify Physical, Occupational, Speech Therapy and/or Massage Therapy benefits. There may be dollar and/or visit limits, preauthorization /referral requirements, or other restrictions. If you have further questions, please contact our business office at 253-874-2998.*