

### **Assignment of Benefit and Release Information**

I give my consent to Core Physical Therapy therapists to provide treatment, examination and/or evaluations as deemed necessary to the above named patient.

I hereby authorize payment directly to Core Physical Therapy of any insurance benefits otherwise payable to me for services. I understand that I am directly responsible to Core Physical Therapy for any charges not covered by my insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Regarding Insurance**

If you have insurance coverage with one of the plans we participate with, we will bill your insurance company along the guidelines of our contract. As a courtesy to our patients we will submit all claims directly to the appropriate insurance party. However, we require that all co-pays or co-insurances be paid at the time of service. Any deductibles or balances due are payable immediately upon receipt of our bill.

### **Missed and Late Appointments**

At Core Physical Therapy we take your treatment seriously. Appointments are scheduled with the same therapist for a 45 minute PRIVATE session. In order to continue to provide this service it is extremely important for you to show up for all of your scheduled appointments. In the event that you will need to cancel your appointment, we ask that you call 24 hours in advance so we may schedule other patients. If you fail to call our office at least 24 hours in advance, all of your future appointments will be removed from the schedule. If this happens you can call the office on the days that you can attend therapy and we will do our best to fit you in the schedule.

Initial Here \_\_\_\_\_

### **Receipt of Notices of Privacy Practices and Medicare Therapy Cap**

I have received a written copy of the Notice of Privacy Practices for Core Physical Therapy, and, if appropriate, Notice of Medicare Therapy Cap.

Signature \_\_\_\_\_ Date \_\_\_\_\_