DATE: ______________________________

PATIENT: ______________________________

469.795.7865 PHONE • 469.795.7866 FAX • www.willardpt.com

PAYMENT POLICY
FINANCIAL RESPONSIBILITY

Willard Physical therapy Associates is a private pay entity. Payment for all services is due at time of service. Further treatment will not be scheduled until payment is made.

INITIAL: __________

CANCELLATIONS AND NO SHOWS

We request a courtesy of cancellations 24 hours in advance. If you do not show up for your scheduled appointment or cancel late, you will be charged a $30.00 cancellation/no show fee. This fee will be collected on your next date of service. If you excessively cancel or no show, your therapy will be discontinued. If you arrive late for your appointment, your treatment time may be shortened to accommodate other scheduled patients.

INITIAL: __________

FILING OF INSURANCE

Willard Physical Therapy Associates is not contracted with <u>any insurance companies</u> but YOU may file services individually. Willard Physical therapy associates will be considered an out of network provider in ALL cases. The receipt you are issued with services is sufficient for filing with your insurance provider. Your insurance provider may not accept out of network providers.

INITIAL: __________

I, ______________________________ , accept these terms of payment policy and financially responsibility.

SIGNATURE: ______________________________ DATE: ____________________

CONSENT TO TREATMENT

Thank you for choosing Willard Physical Therapy and Associates. We appreciate the opportunity to service you. Our mission is to provide you with the highest quality service with optimal outcomes suited to meet the demands of your daily life and schedule. In the event that you have any questions or complaints, please let your therapist know so it can be handled promptly and professionally.

I understand the course of my physical therapy can include education in what limitations I may have, suggestions for changes to posture and activities, manual interventions, instruction in directed exercise, and a home exercise program.

I wish to receive physical therapy treatments and understand that my rehabilitation is dependent on my active involvement in my therapy program.

PATIENT SIGNATURE: ______________________________ DATE: ____________________

LEGAL GUARDIAN SIGNATURE (IF PATIENT IS UNDER 18): ______________________________ DATE: ____________________