Callan-Harris Physical Therapy, P C   1150 University Ave Ste 3   Rochester NY 14607-1647
Phone: 585-482-5060   Fax: 585-482-7982

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment. I agree that parents, guardians, or other personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all services or items provided to me, to my minor/child, or to the patient to whom I have legal responsibility. I understand that my health insurance may not pay for bandages, tape, ionto patches, tubing, Theraband, or other items necessary for my treatment because the items/service may not be a covered benefit under my insurance policy. I understand that if the cost of this service is not paid (in full or at all) by my insurance, that I will be responsible for the cost. I hereby agree to pay Callan-Harris Physical Therapy for the cost of the item or service if it is not covered by my insurance.

I understand that filing a claim with my insurance company does NOT relieve me from my responsibility for the payment of all charges.

SELF PAY patients are required to pay in full for charges incurred at the time services are rendered. Payment plans are available as a courtesy – please speak with the office manager to set this up.

All co-payments are due at time of service and I understand that a $25.00 fee will be charged for any returned checks.

____   ____________   __________________
Signature of Patient, Parent, Guardian or Personal Representative   Date   Relationship to Patient

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____
Name of insurance company(ies)
and assign directly to Callan-Harris Physical Therapy, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges incurred whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions. **I understand that there may be a limit to the number of visits my insurance allows and will pay the hourly rate per visit when exceeding that limit.**

The above-named practice may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

Initial ________

APPOINTMENT CANCELLATION POLICY

Important information for our patients:

Our Physical Therapy Practice requires a 24 hour notice for all cancellations. If a scheduled appointment must be cancelled within 24 hours of the scheduled time, **there will be a charge equal to your co-payment (or a fee of $20.00 if your insurance does not require a co-payment for visits to a specialist). If you are a no show for your appointment, the same charge will be applied.** We are holding the time spot for you and may be able to give the time to another patient who has requested a visit.

Should you have have more than 3 cancellations on day of appointment and/or missed appointments- you will only be allowed to call in on the day you would like to be seen to see if any appointments are available.

Initial ___________   Date ____________

Parent or guardian's initials (if under age 18) ______