



Sutton Place

Physical Therapy

Payment Policies and Procedures

Please read and initial each paragraph and sign below.

We take your health care very seriously and want to provide the highest quality of care possible. Unlike other physical therapy practices, we are proud to offer high quality individual appointment sessions with a licensed physical therapist. Our unique approach allows exceptional results and high rate of patient satisfaction.

Payment Policy:

Patient's responsibility charges such as: copays, coinsurance and deductible will be collected at the time of service. These charges, if applicable, will be explained to you prior to your first visit. We require a credit card to be maintained on file for charging any fees determined to be patient responsibility. You may pay for your patient responsibility charges with cash, check or use the credit card on file.

_____(initial) I hereby agree to pay any and all charges that are not covered by my insurance plan.

Cancellation Policy:

If you need to cancel an appointment, we require 24-hour notification prior to your scheduled appointment to cancel. (If a Monday appointment, please call our office by 4 PM on Saturday) If 24-hour notification is not given, a \$50 cancellation fee will be charged to the credit card on file.

_____(initial)

No Show Policy:

If for any reason you fail to show up for a scheduled appointment without giving 24 hours' notice a \$50 no show fee will be charged to your credit card on file.

_____(initial)

HIPPA: I have read and understand that I have a right to a copy of Sutton Place Physical Therapy's HIPPA privacy notice. I have the right to request restrictions on the use of my information and to revoke my consent at a later date.

_____(initial)

I understand that I am solely responsible for the balance due on my account and agree to pay any unpaid balance due. Benefits are verified but are NOT A GUARANTEE OF PAYMENT/COVERAGE.

_____(initial)

We appreciate your patronage and if you have any questions or concerns, please ask. I have read and fully understand the above policies and procedures of Sutton Place Physical Therapy and agree to these terms.

Signature of Patient or Responsible Party: _____ Date _____