

## **Cancellation Policy**

We, at Coppola Physical Therapy, will make every effort to schedule your therapy appointments at a time that is convenient for you. In the event that you cannot attend a particular scheduled appointment, we ask that you call Coppola Physical Therapy (preferably 12 to 24 hours) prior to that appointment to cancel and/or reschedule that appointment. If you do not call to cancel and do not show up for a scheduled appointment, you could be charged for a missed appointment.

If you miss 3 scheduled appointments, we reserve the right to discharge you from therapy. In order to resume therapy after such time you will need to see your physician, obtain another prescription and call us to schedule a re-evaluation.

Also, if you are more than 15 minutes late for your appointment, it will be left to the discretion of your therapist whether or not you will be treated at that time.

I give permission for Coppola Physical Therapy to contact me at home or at my work for any therapy/insurance related issue.

If you have any questions about this policy, please do not hesitate to ask. Thank you advance for your cooperation

## **Statement of Ultimate responsibility**

I understand that Coppola Physical Therapy will, as a courtesy to me, bill my primary insurance company for services rendered. PLEASE NOTE: Coppola Physical Therapy does not bill secondary insurance company.

I also understand that I am ultimately responsible for any balance on this account. I agree to pay my balance to Coppola Physical Therapy, LLC if either my workers compensation claim is denied or if my private health insurance does not cover these services for whatever reason or if my legal case is not settled in my favor.

I agree to set up a monthly budget fee payment schedule in the event there is a balance on this account after insurance payments or legal case settlements.

I authorize payment of claim forms to be sent direction to Coppola Physical Therapy. I understand that if my health plan has a co-pay option, that co-pay may be applicable on a per visit basis.

I have read the above statements and policies and agree to comply to them.

Patient/Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_