Quiet Corner Physical Therapy

Patients Name (Print): _____Date of Birth: _____

Quiet Corner Physical Therapy Financial Policy

It is the patient's responsibility to acquire and understand their insurance as it pertains to physical therapy. The insurance information obtained from the patient and the insurance company will be used for copayments, deductibles, coinsurance, and other benefits. Copayments, deductibles, coinsurances, and visit limits are often estimates and are often based upon amounts billed for treatment. If there is a discrepancy in the information given, Quiet Corner Physical Therapy will default to the benefits given by the insurance company. Quiet Corner Physical Therapy reserves the right to charge a $25 no show fees for missed visits or cancellation less than 2 hours before the appointment. Any remaining balances will be billed to the patient at the end of their treatment. I agree to pay the owed balance billed by Quiet Corner Physical Therapy/A Plus Physical Therapy, LLC.

By signing below, I certify that I understand and agree with the Quiet Corner Physical Therapy's Financial Policies.

Signature: _____ Date: _____

(Parental or legal guardian signature required for children under the age of 18)

Quiet Corner Physical Therapy consent to treat form

I hereby give Quiet Corner Physical therapy permission to medical treatment, documentation, and billing for services rendered. Quiet Corner Physical Therapy will follow the direction of The Health Insurance Portability and Accountability Act (HIPAA). Medical information may only be disseminated to insurance companies and other medical professionals that may be involved in your medical care.

Signature: _____ Date: _____

Quiet Corner Physical Therapy waiver and release of liability

By signing below, I agree to the waiver and release of liability and it is my intension to

exempt and relieve Quiet Corner Physical Therapy, A Plus Physical Therapy, LLC, and Gregory Haney DPT.

HOLDING LLC from liability for personal injury, property damage or wrongful death caused by

negligence or any other cause.

Signature: _____ Date: _____