Specialized Orthopedic Physical Therapy, Inc.

HIPPA Compliance Policy:
I have read and understand Specialized Orthopedic Physical Therapy's obligations, as well as my rights as a patient, under the Health Insurance Privacy and Portability Act. Specialized Orthopedic Physical Therapy has provided me with general information outlining HIPPA guidelines.

No Show Policy:
Thank you for choosing Specialized Orthopedic Physical Therapy as your physical therapy provider. We are sincerely dedicated in assisting you meet your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program which will result in quicker recovery and better outcomes.

When a patient does not maintain his/her proper schedule, three people suffer. The Patient, because treatment is not being received as prescribed by the patients Doctor and / or Physical Therapist; The Physical Therapist who has reserved that particular appointment for you personally; and any other patient who could have been seen in your place.

If you need to cancel a Physical Therapy appointment, please call us ASAP so we have the opportunity to offer your appointment to another patient. If less than 4 hours notice is given you will be charged a $20 cancellation fee.

If you do not show up for a scheduled appointment, you will be charged a $20 no show fee.

Patient Signature_____Date_____

Consent to Treat Agreement and Release:
I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to Specialized Orthopedic Physical Therapy, Inc all insurance benefits, if otherwise payable to me for services rendered. Specialized Orthopedics Physical Therapy, Inc contacts third party/insurance companies for patient's benefits and eligibility as a courtesy and benefits quoted do not guarantee payment for services rendered. I understand that I am financially responsible for all charges, whether paid or not paid by insurance. I herby authorize Specialized Orthopedic Physical Therapy, Inc to release all information necessary to secure proper payment of benefits. I authorize the use of this signature on all insurance submissions.

Specialized Orthopedic Physical Therapy, Inc cannot be held responsible for injuries or bodily harm that occurs as a result of equipment misuse or failure.

Patient Signature_____Date_____