



PATIENT NAME: _____

Patient Responsibility

I agree to pay for all medical services rendered by Focused Physical Therapy. If Focused Physical Therapy is currently a contracted provider of your insurance company, they will bill them for you. A current insurance card must be present upon first session. In the event your insurance company denies the claim, Focused Physical Therapy reserves the right to bill you as the responsible party for reimbursement. I agree to pay any outstanding balances in this regard. I agree to pay any additional fees and or costs incurred to collect payment of my account. I understand that Insurance benefits and current policy coverage verification is my responsibility, and in any situation where insurance coverage changes, I will be responsible for any unpaid services received by Focused Physical Therapy.

Appointment Cancellation Policy

To provide sufficient care, your appointments are reserved time in the therapist's daily schedule. In the event you are unable to keep your scheduled time it is imperative that you give us a courtesy cancellation notice of no less than 24 hours of that appointment time. If you fail to show up for a scheduled appointment, or do not notify the office of a cancellation at least 24 hours in advance of that appointment time, Focused Physical Therapy reserves the right to charge your account the amount of \$35.00.

Patient or Guardian Signature: _____

Date: _____