Cancellation Policy

Our number one priority is to help you improve your condition quickly and effectively. With the exception of a serious emergency, it is expected that you keep all your appointments so that we may service you to the highest level. If you need to reschedule an appointment, we require at least 12 hours notice (24 hours is preferable). In such a case, please call our office and arrange for a make-up appointment with our receptionist. The make-up appointment needs to be in the same week, preferably the very next day to help you receive the best results. In the instance of a cancellation without 12 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $25 fee._____ INITIAL

Insurance Verification

It is our policy to verify with your insurance carrier whether or not your insurance coverage requires copays/coinsurances or a deductible to be met. You are responsible for paying for services that fall under your deductible/coinsurance. Copays are due on the date of service.

Financial Policy

Understand that you are responsible for paying Coastal Physical Therapy, LLC directly for any applicable deductible/coinsurance/copayment. This is a mandatory requirement when receiving healthcare services. Failure to meet your obligations is a violation of the agreement with your insurance carrier and the carrier may take additional action. Please understand that if you have longstanding unpaid deductibles/coinsurance/copayments, Coastal Physical Therapy, LLC will turn the account over to a collection agency.

In the event that insufficient funds are received, we reserve the right to charge you the bank penalty fee and a $15 handling fee.

Consent for Treatment

I give my consent for Coastal Physical Therapy, LLC to provide me with physical therapy services and treatment considered necessary and proper in diagnosing and treating my condition.

Acknowledgement of Terms and Notice of HIPPA

My signature indicates that I have been provided with a copy of the notice of privacy practices or have waived being provided with a copy of the notice of privacy practices. I have read and understood the above policies.

Patient or guardian signature:_____Date:_____

Witnessed by Coastal Physical Therapy Staff:_____Date:_____