PATIENT POLICIES

moriartypt.com

Thank you for choosing Moriarty Physical Therapy for your rehabilitation needs. We appreciate that you have entrusted us with your health care, and we are committed to providing you with the best patient care possible. Please carefully read through the following policies.

CANCELLATIONS/NO SHOWS: If you should need to cancel any appointment, we require 24 hours notice otherwise you will be charged a **$25 cancellation fee**. If you do not show for your appointment and have not called to cancel, you will be charged a **$50 no show fee**. These charges cannot be billed to insurance and must be paid on or before your next scheduled appointment. If you miss 3 appointments in a 4 week period, we may need to discontinue your treatment.

DEMOGRAPHIC UPDATES: It is important that we have your correct information on file. Please advise us anytime there is any change to your address, insurance, telephone, or other contact information.

PATIENT PRIVACY: Moriarty Physical Therapy is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). During the course of treatment, it may be required to share information with other medical providers. We follow all Federal and State laws and regulations regarding PHI. If you have any questions, please contact one of our staff members. If requested, we can provide you with a copy of our "Statement of Privacy Notice".

DEDUCTIBLES & CO-PAYMENTS might be part of your contractual agreement with your insurance company and it is our responsibility as participating providers to collect those fees. If your insurance plan requires a deductible, we will collect **$125 for your initial evaluation** and **$50 for all follow up visits**, unless otherwise specified on the patient benefit form. You will be billed or credited the difference after we receive an Explanation of Benefits (EOB) from your insurance company. **Co-pays and deductible payments are due at each visit.**

AUTHORIZATION FOR TREATMENT & FINANCIAL AGREEMENT

- I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received within 30 days of statement date. I agree to pay all charges within 30 days of statement date unless prior arrangements have been made with the billing office. I agree to assign my insurance benefits to Moriarty Physical Therapy, if applicable.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

- I authorize Moriarty Physical Therapy to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize my healthcare providers to release personal health information as it pertains to my rehabilitative care if any is requested by Moriarty Physical Therapy.

I have read and agree to the above information.

Patient Name: _____

_____ _____

Signature of Responsible Party (must be over 18 years old) **Date**