Hallett
PHYSICAL THERAPY

133 Falmouth Road Mashpee, MA 02649

508-648-8297 www.hallettpt.com

CONSENT TO TREATMENT

I hereby authorize the professional staff at ***Hallett Physical Therapy*** to examine and treat me with physical therapy for the symptoms I have been referred here for or referred myself for.

_____ _____ _____

Patient/Parent/Guardian Signature Printed Name Date

CANCELLATION / NO SHOW POLICY

When you schedule an appointment with me you are "purchasing" that time. It is yours unless you cancel it PRIOR to 48 hours of your appointment time. The charge for a scheduled appointment not cancelled within this time frame is $50. This policy also applies to an appointment you did not cancel because you have decided not to continue therapy. Charges for late cancellations or missed appointments are NOT billable to you insurance company.

I have read the above and agree to the terms of the cancellation policy _____

HIPAA REGULATIONS

I understand that ***Hallett Physical Therapy*** complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed an full payment is received. I also authorize the release of any information pertinent to my case to my insurance company, adjuster, attorney, or medical provider for the purpose of securing payment. This authorization remains in effect until 90 days from the date of the last bill collected.

_____ _____ _____

Patient/Parent/Guardian Signature Printed Name Date

ASSIGNMENT and INSTRUCTION for DIRECT PAYMENT to HEALTH PROVIDER

I hereby instruct my insurance company/companies to pay by check made out to and mailed directly to ***Hallett Physical Therapy*** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

_____ _____ _____

Patient/Parent/Guardian Signature Printed Name Date

BIOFEEDBACK

An important part of your treatment may include the use of biofeedback. This will be fully explained prior to receiving such treatment. A special sensor/electrodes are required for treatment, the cost of which may not be covered by your insurance company. By signing below you agree to the one time charge of $45 that is payable at the first session

I agree to pay the one time $45 equipment fee. _____