CAHILL PHYSICAL THERAPY, INC.

INSURANCE BENEFIT VERIFICATION

I have reviewed my insurance benefits and fully understand my responsibilities for co-payments, deductibles and number of treatments allowed per my insurance company and plan. I have asked questions concerning my coverage as needed and fully understand my responsibility for the overall treatment.
I further understand that when services are no longer of medical necessity or insurance benefits have been exhausted, I will be discharged on my own recognizance with the appropriate home care plan. I may continue physical therapy treatments at Cahill Physical Therapy for the out of pocket rate.

By signing below, I agree to adhere to the benefits in my insurance plan and to the plan of care set forth by the physical therapist in my case.

24 HOUR CANCELLATION POLICY

I agree to give at least 24 hours' notice when canceling an appointment with Cahill Physical Therapy, Inc. Failure to do so will result in a charge of a **$50 LATE CANCELLATION FEE** to be paid at the time of the next visit.

By signing below, I agree to adhere to the above mentioned 24 hour cancellation policy and understand that I will be charged a fee for canceling my appointment within the 24 hour time frame from my scheduled appointment.

HIPAA ACKNOWLEDGEMENT

The Federal Health Information Portability and Accountability Act (HIPAA) requires that health care facilities and their employees, handle all personal information with care and respect for clients privacy. We will not release your personal health information to any individual not directly related to your healthcare without your approved consent.
Please review the HIPAA information provided and sign below.

ASSIGNMENT OF BENEFITS

Patient Name: _____

Social Security Number: _____

Primary Insurance: _____

Secondary Insurance:_____

I hereby authorize CAHILL PHYSICAL THERAPY, INC to directly bill and furnish to my insurance carrier(s), any and all requested information concerning my health care.

I authorize my insurance carrier(s) to pay CAHILL PHYSICAL THERAPY, INC directly for services rendered.

I further agree to all terms and conditions listed above for services provided.

Signature: _____ Date: _____
(Patient or Legal Guardian)