**Physical Therapy Patient Agreement**

Thank you for choosing Diamond & Schultz Physical Therapy for your rehabilitation needs. Please read and sign the following agreement; it lays out our billing, scheduling and cancellation procedures. If you have any questions please ask for clarification.

- All patients attending physical therapy must have a valid, written prescription by a medical doctor, osteopath or podiatrist. Patients are responsible for scheduling and confirming appointments with the front desk.

- Payment of all fees is expected at time of service or via credit card on file. We will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payment or any claims denied by your insurance carrier.

- I hereby authorize Diamond & Schultz Physical Therapy, having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. *I understand that if at any point my insurance coverage changes, I am to notify administrative staff prior to my next visit.* Failure to do so will result in me being responsible for the full amount of all services.

- A Scheduled appointment must *be cancelled at least 24 hour hours in advance* or a $50.00 Late Cancel Fee will be assessed. Similarly, if you do not show up for a scheduled appointment the fee will be assessed. This fee is due on the next visit and is not billable to any insurance carrier.

- In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to Diamond & Schultz Physical Therapy (DSPT) all rights, title and interest in the benefits payable for services rendered by DSPT provided by my insurance policy. I hereby authorize my insurance carrier to pay direct to DSPT all benefits due under the policy. If DSPT is unable to collect payment for services rendered herein or if I fail to forward any and all monies received by me from my insurance carrier for rendered services to DSPT and they must use a collection agency I will be responsible for all collection and/or attorney's fees incurred, in addition to interest accruing from the date of service. A photo static copy of this authorization shall be considered as effective and as valid as the original contract.

**I have read and understood this agreement.**
**Patient Signature: _____ Date: _____**