135 South Peru Street
Plattsburgh, NY 12901
Where Healing Happens!

PEARL
PHYSICAL THERAPY

Phone: 518.563.7777
Fax: 518.563.7770
PearlPhysicalTherapy.com

NOTICE REGARDING CO-PAYS AND INSURANCE REIMBURSEMENT

Co-pays are due on the date of service. Please note that in some cases you may be billed directly for a portion of expenses related to your care at Pearl Physical Therapy. This may occur for some or all of the following reasons:

- Your deductible has not been met
- Your co- pay has not been paid
- Your service is not covered by your insurance
- Your service provider is considered "out of network"
- Your insurance policy has changed

IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY PEARL PHYSICAL THERAPY OF ANY CHANGES TO THEIR INSURANCE POLICY OR INSURANCE CARD, AND TO KNOW THEIR LEVEL OF BENEFITS.

Please initial: _____ I have read and understand all the terms of this policy.

CANCELLATION POLICY

Our goal is to give personal and quality care and an appointment time is your reserved time. We will make every effort to see you on time and request that you arrive on time for your reserved appointment. Thus, we request at least a 24-hour notice of cancellation or change of appointment. There will be a $35.00 fee charged for any broken appointments without proper notice. *If calling to cancel after business hours, please leave a voice message with your name, therapist, and appointment date & time.*

Please initial: _____ I have read and understand all the terms of this policy.

CONSENT OF TREATMENT

I give my consent for PEARL PHYSICAL THERAPY, P.C. to furnish medical care and treatment considered to be necessary for my diagnosed condition.

RELEASE OF INFORMATION

I give my permission to PEARL PHYSICAL THERAPY P.C. to release information to my physician, insurance company, attorney, and Assignees and/or Beneficiaries.

PATIENT INFORMATION CONSENT

I have read and fully understand PEARL PHYSICAL THERAPY P.C. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, obtaining prescribed medical equipment from a vendor, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that PEARL PHYSICAL THERAPY P.C. will consider requests for restrictions on a case-by-case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the PEARL PHYSICAL THERAPY P.C. Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Please initial: _____ I have read and understand all the terms of this policy.

PRIVACY OF RECORDS AND INFORMATION RELEASE FOR BILLING PURPOSES

I acknowledge the use of a billing service (*Claims Connection*) located in Plattsburgh to bill for those charges to be issued to my insurance company. When technology permits, these claims may be submitted electronically. I acknowledge *Claims Connection* being given a copy of my registration form in order to process these claims and/or to maintain a record of my account. If necessary, I authorize *Claims Connection* to contact my insurance company to check on claims submitted for payment for services.

Please initial: _____ I have read and understand all the terms of this policy.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY. (See Front Desk for handout)

PEARL PHYSICAL THERAPY, P.C. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

*I have read and understand all the terms of these policies.

Patient/Guardian Signature: _____ Date:_____
