

NIAGARA PHYSICAL THERAPY

PATIENT NAME: _____ SIGNATURE: _____

ASSIGNMENT AND RELEASE

I hereby authorize Niagara Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have insurance coverage and assign all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges.

CO-PAY AGREEMENT

\$ _____ Each Visit
\$ _____ Yearly Deductible
_____ % Of each Treatment

Any changes to your insurance plan could affect your coverage. **Please notify us immediately of any changes.** You are responsible for co-pays, co-insurance's and deductibles, and any other provisions stated in your plan. If you have any questions regarding your coverage, please ask our office staff and/ or contact your insurance carrier.

Patient Signature

Witness/ Staff Signature

Date

Date

WORKMANS COMPENSATION OR NO FAULT

Workman's Comp No Fault

Employers Name: _____

Address: _____

Phone#: () - _____

Insurance Company Name: _____

Address: _____

Phone#: () - _____

Date of Incident: _____ SSN: _____

CANCELLATION POLICY

24 Hours notice is required to cancel an appointment. When you reserve an appointment and do not show or cancel we do not have enough time to place someone else who may have preferred your time period. If a patient fails to cancel prior to an appointment it will be considered a NO- SHOW.

If a patient NO-shows for 2 appointments or cancels 3 appointments you will be discharged and referred back to their respective doctor. I understand that I also may be subject to a \$30 fee if I fail to provide a 24 hours notice. I have been informed of this cancellation policy and agree to its terms and conditions.

INITIALS _____