HPTNYC

HOME PHYSICAL THERAPY

Acknowledgements, Financial Responsibility, Cancellations

"We": refers to HPTNYC INC or affiliates. "I" refers to any individual receiving treatment by HPTNYC INC, or affiliates.

Release of Information

We are authorized to release pertinent medical information to your referring physician.

We are authorized to release medical information to your insurance company regarding coverage for services performed to the patient.

HIPAA Acknowledgement

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices as required by HIPAA.

Guarantee of Payment/Financial Responsibility/Insurance

I agree to pay HPT NYC INC in full at the end of each treatment session, unless otherwise agreed upon by both parties in writing.

I understand that any balance after insurance reimbursement is my/our responsibility. I agree to pay the balance within 14 days of receipt of invoice.

HPT NYC Inc is not responsible for non-payment or lack of reimbursement by a patient's insurance company, should there be issues with reimbursement, either current or retroactively.

We will not engage in communication with the patient's insurance company unless for the purposes of obtaining medical records. We will not engage in communication with the patient's insurance company for billing purposes, unless otherwise agreed upon.

Cancellations

I understand that if I am unable to attend a scheduled appointment, I am required to cancel the appointment by email or call 12 hours prior to the said appointment; otherwise a fee of 50% of the agreed appointment fee will be incurred for late cancellations. This fee is not reimbursable by insurance.

Consent

By signing my name below, I verify that I have read and agree to the information contained in this packet and that the information I have provided is true and accurate.

Patient's signature (or responsible party if the patient is a minor or unable to sign. Include relationship)

Date