



Patient Responsibilities

Please read and initial each of the following. Sign and date at the bottom.

- It is the patient's responsibility to know your insurance benefits and policy requirements for office visits and procedures (therapy). _____ initial
- It is the patient's responsibility to bring your current insurance card(s) and method of payment for each office visit or procedure (therapy). _____ initial
- It is the patient's responsibility to update your insurance information, current address and contact information for our records. Failure to do so will cause the patient to become responsible for all charges. _____ initial
- It is the patient's responsibility to provide a current therapy prescription and/or referral prior to treatment. _____ initial
- It is the patient's responsibility to inform the front desk and therapist if you have been seen at another clinic for physical therapy, hand therapy, or speech therapy. _____ initial
- It is the patient's responsibility to provide a pre-authorization (if required by your insurance) or a letter of medical necessity (if required) from your physician prior to treatment. _____ initial
- It is the patient's responsibility to inform the front desk and the therapist if your treatment is the result of an auto accident or if you were injured at work or school. _____ initial
- It is the patient's responsibility to keep follow-up appointments as scheduled. Your therapy program requires a commitment and attending your appointments on a consistent basis is necessary for you to achieve optimal improvement. Failure to show up for appointments can result in a delay of your Plan of Care. Your attendance is critical. _____ initial
- It is the patient's responsibility to notify our office 24 hours prior to your scheduled appointment if you are unable to keep your appointment. Failure to do so will result in a **\$25.00** no show/cancellation fee which must be paid prior to scheduling your next appointment. _____ initial
- Failure to keep 2 consecutive appointments, no shows, and accounts no longer maintained in a good faith status may result in termination of your provider-patient relationship with Spooner Physical Therapy. _____ initial
- It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of those decisions. _____ initial

I have read and understand my responsibilities as a patient. All of my questions have been answered.

Patient Name (please print)

Patient Signature (parent or legal guardian)

Date