Financial Policy

Patient Name: _____

The service that you are electing to receive implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of fees. We will verify your coverage and bill your insurance carrier on your behalf. If your insurance company denies coverage, you are responsible for the fee for each visit. You are responsible for payment of any deductible or co-payment. We collect copays at time of service. Co-insurances and deductibles will be billed.

Cancellation Policy

If it is necessary for you to cancel an appointment, we respectfully request 24-hour cancellation notice so someone else may use the appointment time. **If you do not cancel within 24 hours or no-show for an appointment, you may receive a $35 charge.** We realize that emergency situations do arise (as they may for the office, causing the office to have to change the appointment). We will extend you one courtesy same day cancellation in case of illness or emergency.

I have read the above policy regarding my financial responsibility to Spine and Orthopedic Specialists, Inc. for providing rehabilitation services to me or the above named patient. I authorize my insurer to pay any benefits directly to Spine and Orthopedic Specialists. I agree to pay Spine and Orthopedic Specialists the full and entire amount of all bills incurred by me or the above named patient; or if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature/Guarantor Signature: _____
Date: _____

DO YOU HAVE A FOLLOW UP VISIT SCHEDULED WITH YOUR REFERRING PHYSICIAN?

IF **YES**, PLEASE PROVIDE THE DATE: _____

IF **NO**, please notify us when you schedule your follow up visit.

SOS PT
Spine and Orthopedic Specialists
Physical Therapy