NORTHERN ARIZONA
PHYSICAL THERAPY ASSOCIATES

Acknowledgement of Office Policies

Please read carefully and be sure to ask questions you might have before signing the document.

Appointment Scheduling: We at Northern Arizona Physical Therapy Associates, PLLC are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) or more appointments without 24 hour notice, you may be dismissed from care and your file may be closed.

Consent for Treatment: I, the undersigned, give Northern Arizona Physical Therapy Associates, PLLC my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym and/or pool areas are common areas accessed by patients, gym members and guests and as a result there may be incidental contact with personal health information.

Private Health Insurance: I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Assignment of Payment: I hereby authorize my insurance company and/or my attorney to pay direct to Northern Arizona Physical Therapy Associates, PLLC any monies due on my account for professional services rendered. The patient agrees to pay any applicable deductible amount, copayment, or coinsurance percentage, as outlined in their insurance policy, for covered medical services rendered. A credit card is required to be kept on file and payment is due at the time of service. The patient authorizes the healthcare provider to utilize the card on file to auto charge their credit card for any outstanding balances resulting from covered medical services rendered as insurance processes each claim. Patients will be sent receipts of billed charges via email if provided. Otherwise copies can be requested directly from the front desk.

Acknowledgment and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Authorization to Release Information: I have read and fully understand Northern Arizona Physical Therapy Associates, PLLC's Notice of Privacy Practices. I understand that Northern Arizona Physical Therapy Associates, PLLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payments.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: _____ Date: _____