



**ALTA PHYSICAL THERAPY, P.C.**

Patient Name \_\_\_\_\_

Patient # \_\_\_\_\_

**CLINIC POLICIES**

- We require payment of your estimated co-payment or deductible at the time of service.
- You, (not your Physical Therapist or the office staff), are responsible for scheduling all of your appointments. Appointments must be canceled a minimum of **twenty-four (24)** hours in advance.
- If possible, please make other arrangements for your child’s care during your appointment. If your child must accompany you, he/she will need to stay in the small treatment room with you at all times.
- I am responsible for payment of all durable goods and supplies; including tape and theraband.
- Please discuss questions about insurance matters with our Office Manager. At your request, we will be happy to help you receive maximum benefits. **However, you are ultimately responsible for charges accrued as a patient of ALTA Physical Therapy, P.C.** We are not a party to the contract between you and your insurance company, **or** other people listed as responsible for your account.
- I acknowledge that if I do not pay this account and the account is assigned to a collection agency, I will be liable for any collection fee charged by the agency plus any other collection costs and any reasonable attorney fees and court costs.
- I, the undersigned, do give **permission to release information** to 3<sup>rd</sup> party carrier(s); do assign all insurance benefits for treatment from the above named provider; and request that this assignment remain on file with my insurance carrier.

*SIGNATURE* \_\_\_\_\_ *DATE* \_\_\_\_\_

**GENERAL REQUEST FOR CONSENT TO  
PHYSICAL THERAPY TREATMENT**

- By signing below, I am hereby **requesting** and **consenting** to a physical therapy **evaluation** and **treatment** to be performed by therapists, therapist’s designees, or assistants.
- I recognize that the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guarantees have been, or can be made, regarding the likelihood of success or outcome of any therapy.

*SIGNATURE* \_\_\_\_\_ *DATE* \_\_\_\_\_

*WITNESS* \_\_\_\_\_