

Bodywise Physical Therapy LLC

CANCELLATION POLICY

We, Bodywise Physical Therapy LLC, will make every effort to schedule your therapy appointments at a time that is convenient for you. **In the event that you cannot attend a particular scheduled appointment, we ask that you call Bodywise Physical Therapy (preferably 12 to 24 hours) prior to that appointment to cancel and/or reschedule the appointment. If you do not call to cancel and do not show up for a scheduled appointment, you could be charged for a missed appointment.**

If you miss 3 scheduled appointments, we reserve the right to discharge you from therapy. In order to resume therapy after such time, you will need to see your physician, obtain another prescription and call us to schedule a re-evaluation.

Also, if you are more than **15 minutes late for your appointment**, it will be left to the discretion of the therapist whether or not you will be treated at that time.

If you have any questions about this policy, please do not hesitate to ask. Thank you for your cooperation.

Patient Signature: _____ **Date:** _____

STATEMENT OF ULTIMATE RESPONSIBILITY

I understand that Bodywise Physical Therapy LLC will, as a courtesy to me, bill my insurance company for services rendered and send a monthly statement to me.

I understand that I am responsible for any co-payment at time of services rendered. I also understand that I am responsible for any deductible or co-insurance associated with my health insurance plan.

I understand that if services rendered from the initial visit to present are non-referred/non-covered services, **I will be responsible for payment**. I accept full responsibility for all services that have not been authorized by my physician or insurance company.

I agree to pay my balance with Bodywise Physical Therapy LLC if either my Workman's Compensation claim is denied, my MedPay/PIP is exhausted, my private health insurance does not cover services or if my legal case is not settled in my favor.

I understand that I am ultimately responsible for any balance on this account.

I understand that if the balance on this account is not paid in full I will be sent to collections.

I authorize payment of all claim forms directly to Bodywise Physical Therapy LLC.

If you have any questions regarding your account you may speak with Bodywise Physical Therapy or their billing company BMS, at any time.

Patient Signature: _____ **Date:** _____

**Bodywise Physical Therapy LLC ♦ 629 Calef Highway, Suite 103 ♦ Epping NH 03042
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