GSPORTS
PHYSICAL THERAPY

PATIENT RESPONSIBILITIES

We want to make sure you have a positive and successful rehabilitation experience. In order to better serve you and assure that your physical therapist can help you safely and effectively reach your goals, your participation and commitment to rehabilitation is required. Please read and initial next to your responsibilities outlined as follows:

Attendance Policy

_____ Initials

I am responsible for attending physical therapy sessions as scheduled. I understand if I am late or fail to give appropriate cancellation notice, I will hinder my potential outcome. I understand that my physical therapist has designated appointment times to assist me in my recovery. I will provide at least **24 hours** notice to cancel a scheduled appointment. Failure to comply with this policy may result in a **$65.00** charge. I understand that this charge will be billed DIRECTLY to me, the patient, and is NOT covered by insurance. I recognize that my attendance is not dependent on the receipt of an email reminder.

Payment Guarantee

_____ Initials

I agree to pay G Sports Physical Therapy, Inc., its subsidiaries, and/or affiliates for the services provided to me or the patient named herein. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

Estimated Financial Responsibility

_____ Initials

Per my insurance company _____, I understand that I have a $_____ deductible. Until I meet this deductible, I am responsible for the full allowable amount which is **estimated** to be $_____ for the first visit and $_____ for each follow-up visit. Once the deductible has been met, I will be responsible for a co-insurance/co-payment of $_____ per visit. Since these amounts are only estimates, any balance that is over the estimated amount will be billed to me and any balance that is under the estimated amount will be refunded to me, after my claim has processed by my insurance company.

I understand that my estimated financial responsibility above is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of G Sports Physical Therapy Inc., its affiliates and/or subsidiaries.

I have read, understand, and agree to the above policies.

_____ _____
Patient or Guardian Signature Date

_____
Patient Name Printed

_____
Parent or Guardian Name Printed