PLATINUM
PHYSICAL THERAPY

Consent for Treatment

I, the undersigned, a patient at Hopkinton Physical Therapy & Sports Medicine, Inc., do hereby consent to treatment as prescribed by my provider, a licensed physical therapist in the state of Massachusetts.

Billing

I understand and agree that health and accident insurance policies are an arrangement between me and an insurance carrier. Furthermore, I understand that as a courtesy Hopkinton Physical Therapy & Sports Medicine, Inc. will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Hopkinton Physical Therapy & Sports Medicine, Inc. I also understand that I am ultimately responsible for payment of all services rendered unless otherwise provided by law.

Deductibles, Coinsurance, and Co-Payments

Co-payments are to be paid at the time of service unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time payment from the insurance company is received. Payment is due within 30 days of the date on the invoice received and it is my responsibility to keep my payments current.

Cancellation/No-Show Policy

Cancellations should be made with a minimum of **24 hours** notice prior to the scheduled appointment time. A **$50.00** fee may be enforced for **no shows** or **late cancellations**.

With my signature I agree to all of the above terms and conditions. Additionally, I confirm that I have received and read a copy of Hopkinton Physical Therapy & Sports Medicine, Inc.'s Notice of Privacy Practices.

_____

Patient or Legal Guardian's Signature Date

Benefits verified_____

Co-Pay _____ After Meeting Deductible of _____

Co-Insurance _____ After Meeting Deductible of _____