



Consent to Treatment and Cancellation Policy

You will be expected to pay for your visit, in full at the time of service. For your convenience we accept cash, checks, Venmo, Paypal, major credit cards, and debit cards. Cards are subject to a variable 3.0 - 3.75% processing fee. Returned checks are subject to a \$12 NSF Fee.

We are happy to provide invoices with all CPT codes and information necessary to submit to your insurance company for reimbursement. R3PT does not guarantee reimbursement. All written documentation will gladly be provided per insurance request.

MISSED APPOINTMENT POLICY:

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving adequate care. Therefore, R3PT reserves the right to charge a fee of \$85.00 for each appointment not cancelled within 12 hours advance notice. No Show appointments or cancellations with less than 3 hours notice are subject to the full \$150 fee. Thank you for your anticipated cooperation.

HIPPA/PRIVACY POLICY:

We are required by law to maintain the privacy of your health information and provide you with a copy of our Privacy Policy. Specifically HIPPA and R3PT's Privacy Policy individually identify you and relate to (1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare. Under no circumstances is your private healthcare information given to anyone unless your consent is given. If you wish for someone to be authorized to assist you with your care, written consent will be needed. We may use health information about you to provide, coordinate or manage your healthcare and related services. We may disclose health information about you to your doctor, or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care. If you have any further questions about our HIPPA or Privacy Policy we have a copy at the front desk.

I have read and agree to the terms of this statement.

I consent to receive Physical Therapy care from R3PT

By signing below, you acknowledge that you have received this notice and understand this policy

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if patient is a minor or an adult unable to sign)

Relationship to Patient