

## WELCOME TO OUR OFFICE

Here are some of the most commonly asked questions about our services. Please take a minute to review this carefully and feel free to ask questions.

**PAYMENT:** As a courtesy to our patients we will bill your insurance company. **We do require you to pay your percentage of responsibility or co-pay at the time of each treatment.** If your insurance company has failed to pay us within a 45-day period, we will expect you to pay the balance of your bill in full (Visa and MasterCard accepted)

The average initial visit is approximately 45-60 minutes at an estimated charge of \$250.00; subsequent visits are approximately \$180.00 per hour. The charges depend on procedures or modalities performed, and length of appointment. Supplies and equipment are not paid for by insurance carriers. We expect payment for these at time issued.

**REGARDING APPOINTMENTS:** Please call 24 hours prior to cancel an appointment. Early 7:00-9:00 a.m. and late 4:00-6:00 p.m. appointments are at a premium. **You will be charged \$50.00 for any missed appointment, or one that is not canceled within 24 hours.** Your insurance company will not cover this charge. Our goal is quality patient care and helping those in need. Timely cancellations will allow us to provide services to other patients. Punctuality is appreciated so you can receive the maximum benefit from your appointment.

**WORKER'S COMPENSATION PATIENTS:** As of January 1, 2004 Worker's Compensation will only allow 24 approved visits per year unless otherwise approved by the insurance company. Please note that this office will notify your Worker's Compensation Insurance adjuster of non-compliance after two missed appointments.

**REPORTS TO PHYSICIANS:** Please let us know 7 days in advance when your next M.D. appointment is, so we can reassess your status and send a letter informing them of your progress. Medicare requires a plan of care/prescription every 30 days.

**TEAM APPROACH:** At one time or another due to sickness or vacation time you may see a different physical therapist, assistant or aide. Please let us know if you are uncomfortable with this.

**PATIENT INFORMATION CONSENT:** I have read and fully understand Larchmont Physical Therapy's notice of information practices. I understand that Larchmont Physical Therapy may use or disclose personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that LPT will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby authorize the release of any medical or other information necessary to process insurance claims and authorize payment of medical benefits to Larchmont Physical Therapy for services rendered. I have read this carefully and understand and agree that I am fully responsible for all medical bills and services rendered to me and that my health insurance may deny charges based on review of medical necessity and if so I am responsible for payment in full.

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Patient Signature  
(Parent signature if patient is a minor)

Date:

**Thank you for choosing Larchmont Physical Therapy!**

