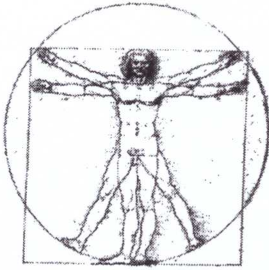

Recesso: Physical Therapy, LLC
11 Garden Road
Ph (603)382-3336 Fax (603) 382-3633
www.recessophysicaltherapy.com

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the release of information to my doctor and my insurance company necessary to process this claim.

Additional release(s) issued to: ______________________________

Initials: ____________

PATIENT PRIVACY POLICY: I acknowledge that a copy of the patient privacy policy was offered or issued to me.

Initials: ____________

ASSIGNMENT OF PAYMENT: I assign payment of medical benefits to Recesso Physical Therapy for services rendered.

Initials: ____________

TO OUR MANAGED CARE PATIENTS: I understand that if services are denied due to absence of prior approval from my primary care physician, I will be personally responsible for those fees.

Initials: ____________

RESPONSIBILITY FOR PAYMENT: I understand that I am responsible for full payment for services rendered. Any charges not covered by my insurance company, including co-payments, deductibles, and supplies will be payable at the time of treatment.

Initials: ____________

CANCELLATION POLICY: I am aware that appointments cancelled without 24-hour notice will result in a $50.00 charge that I am responsible for. One missed appointment or no show without proper notice may result in discharge for non-compliance.

Initials: ____________

I HAVE READ AND AGREE TO THE ABOVE-MENTIONED POLICIES. ALL INFORMATION I HAVE PROVIDED TO RECESSO PHYSICAL THERAPY, LLC IS ACCURATE TO THE BEST OF MY KNOWLEDGE

______________________________ ____________________

Signature of Patient/Legal Guardian Date