

PLEASE SIGN AND RETURN

- I understand that I am responsible for obtaining all referrals and prescriptions needed for insurance coverage.
- I understand that I am responsible for understanding the benefits available to me under my personal insurance plans, including deductibles or co-pays.
- I will be personally responsible for all deductible or co-pay expenses.
- I will assume financial responsibility for any charges not covered by insurance.
- Medicare patients will be responsible for getting a new MD prescription every 30 days.
- I understand that Kennedy Brothers Physical Therapy WILL NOT bill my attorney directly. I understand my claims will be submitted directly to the insurance carrier and I will provide the office with the appropriate information. Kennedy Brothers will forward copies of billing information to my attorney with my written request.
- I will make every effort to cancel my appointments with 24 hours notice. I understand that cancellations and no-shows may affect others that are in need of appointments. I understand that if I am consistently not showing up for appointments at their scheduled time or cancelling appointments with less than 24 hours notice, I may be charged a \$25 cancellation fee.
- Co-payments will be due at the time of your visit.

I have read and understand the above. If under 18, a parent or guardian must sign below.

Name: _____ Date: _____