Pittsburgh Performance Physical Therapy

HIPAA Notice of Privacy Practices:

I understand that Pittsburgh Performance Physical Therapy referred to as "PPPT" may share/send copies of my health information or records to another provider or health plan as needed for coordination and management of my health care and related services, but will make every effort to keep my health information protected and confidential.

I acknowledge that the Pittsburgh Performance Physical Therapy Notice of Privacy Practices was made available to me. Please check one: Requesting email copy ○ Requesting printed copy ○

X _____ Date: _____

Patient signature

Cancellation Policy:

It is expected that I actively participate in my recovery process and give full effort toward the goals established by myself and my physical therapist. I realize that attendance is critical to my success and the success of the program, therefore, missed appointments may be reported to my physician, insurance, and/or employer. As a courtesy to the provider and to other patients, a minimum of 24 hrs advance notice is required for cancellation of a visit. This allows the clinic the time to reassign the appointment time to another patient.
I understand that if I fail to show for a scheduled visit without notification I may be subject to a $50 fee and if I fail to cancel/reschedule any visit less than 24 hours prior to the scheduled time, I may be subject to a $25 fee. I understand that these fees are not covered by insurance and that PPPT may use my credit card on file to use as payment when and if needed.

I hereby acknowledge that I have read and understand the above statement regarding the No Show/Cancellation Policy.
X _____ Date:_____

Patient signature

Financial agreement and assignment of benefits:

I hereby authorize Pittsburgh Performance Physical Therapy "PPPT" and any subsidiary to administer treatment required for my diagnosis, to apply for benefits from my insurance carrier(s) listed. I also understand that it is my responsibility to know my insurance benefits and coverage limitations and will be responsible for any service that my insurance carrier does not cover, although PPPT agrees to notify me of any treatment that may not be covered before it is included in my treatment plan.

I understand that all fees (eg. copay) for services are due from me the day of treatment. I also understand that I am responsible for any fees charged for returned checks, regardless of any payer, third-party interest, or the resolution of any legal action or lawsuits in which I may be involved. I further understand that PPPT reserves the right to pursue delinquent accounts via third -party collection agencies or attorneys. In the event my bill is referred for collection, I agree to pay all collection agency fees, attorney fees, court costs, service of process fees and any late charges per month for all balances over 30 days, in addition to the amount owed for services rendered (as applicable by state guidelines).

X _____ Date:_____
Patient signature