Financial Responsibility
I understand that I am financially responsible for charges including co-insurance, deductibles, copayments, and services not covered by my insurance. **Payment for co-payment and non covered services is due at the time of service. Deductibles and coinsurance will be billed as claims are processed.** Any payments made at the time of service will be applied to my account and I will be billed for the remaining balance; payable upon receipt.

Information Verification
I understand that it is my responsibility to contact my insurance company and verify my physical therapy benefit as it pertains to my treatment at Medfield Orthopedic & Sports Physical Therapy LLC (MOST) including **co-pays, co-insurance, deductibles, visit limits, benefit year and referral requirements**. I also acknowledge that **I am responsible for notifying MOST about any insurance changes** that occur during the course of my treatment prior to the effective date of my new insurance. Failure to do so may result in unpaid claims that become my financial responsibility.

Information Release
I hereby authorize Medfield Orthopedic & Sports Physical Therapy LLC to release my records to my insurance company and/or my attorney information concerning my diagnosis and treatment for the purpose of processing claims.

Insurance Payment
I hereby authorize my insurance company to make payment directly to Medfield Orthopedic & Sports Physical Therapy LLC for covered services rendered.

Cancellation and No-Show Policy
I understand that if I am unable to keep an appointment, **a 24 hour notice** is required so that my appointment time can be offered to another waitlisted patient. Failure to notify MOST will result in a $30 charge and must be paid at the time of my next visit. Calls may be made to the answering machine after hours or on weekends. I acknowledge receipt of this policy.

HIPAA Regulations
I acknowledge Medfield Orthopedics & Sports Physical Therapy LLC provides protection according to HIPAA regulations as outlined in the privacy policy. I have been offered a full copy of MOST's HIPAA policy.

I have read the above and understand and agree to terms and conditions outlined.

PaitientSignature____Date__________

You may request a copy of this form at any time.