

Patient Registration

**BACK TO ACTION
PHYSICAL THERAPY
PLC**

Waitsfield Vermont

PATIENT ACKNOWLEDGEMENT FORM

Please initial each line and sign at the bottom.

EXPECTATIONS OF PATIENTS

_____ I understand that if I am unable to attend a scheduled appointment I need to CALL 24 hours in advance – or as soon as possible!

- You will be billed a \$45.00 “NO SHOW FEE” for any non-cancelled appointments. This will be billed to you personally, not to your insurance. This measure is to dissuade patients from expending valuable time that could be utilized by other patients.

_____ I understand that cell phones are to be turned off or on silent upon arriving to the clinic.

_____ I acknowledge that I have received a copy of the Back To Action Billing Information handout and that I am responsible for knowing what costs my insurance plan will cover.

_____ I understand that bills will be sent in the name of the patient, even if the patient is a minor.

Signature: _____
(Parent or Guardian if patient is under 18)

Date: _____