



Services Treatment Information

Welcome to LaFayette Physical Therapy. In order to make your treatment effective and problem free, we ask you to review our outpatient policies:

1. **Late Policy:** If you are going to be late please call your therapist and let them know. If you are going to be more than 15 minutes late we may need to reschedule your appointment to ensure that you and the other patients have quality care without any time constraints.
2. **Absenteeism Policy:** If you have 3 consecutive absences of your scheduled visits you will be discharged. To return to therapy you will need to provide a new prescription from your physician.
3. **Payment Requirements:** You are responsible to pay your deductible and/or co-pay as required by your insurance company(s). Your co-pay is due at the time service is rendered. If you have any questions regarding your co-pay or deductible please contact your insurance company or our office at (706) 638-5983. Again, our relationship is with you not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
4. **Cancellation Policy:** Our office requires a **24-hour** notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a **\$25.00** charge (at our discretion) for a missed appointment without **24-hour** notification to the office.
5. **Privacy Consent:** Our office publishes a monthly newsletter to keep our patients updated. We would like to publish each patient's birthday in the appropriate month as well as list any winners of referral/puzzle prizes. Please circle the option that applies to you.

Okay to publish

Do not publish

Please sign below that you have read and understood the above policies:

Patient Signature

Date