**Balance Point Physical Therapy**
**Acknowledgement of Notice of Privacy Practice**

Patient Name: _____

We keep records of the health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Balance Point PT Privacy Officer.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the notice.

_____ _____ Patient

Signature (or legal authorized individual) Date

_____ _____ Printed name if

signed on behalf of the patient Date

**Patient Financial Responsibility and Cancellation Policy**

I assign all payments for physical therapy services rendered to myself or dependents to Balance Point PT. I understand that I must check with my insurance provider to confirm specific terms of physical therapy coverage. I accept responsibility for any services not covered by my insurance policy and for any service I choose to submit to my insurance company.

- Cancellations: Please call no less than 24 hours prior to your appointment to cancel. If you fail to call at least 24 hours in advance, a $40 fee will be applied to your account for each missed visit.
- After two consecutive missed appointments, Balance Point reserves the right to cancel future appointments.
- Cash Patients pay at the time of your visit.
- Notify the front desk if you have new insurance, change of billing address, or a new phone number.

***All paperwork must be filled out by hand. We do not accept electronic or emailed versions.**

_____ _____

Signature Date