



## **WellnessPT Physical Therapy, P.C. Financial Consent, Payment, and Cancellation Policy**

### **Financial Responsibility**

I, the undersigned, understand and agree to be financially responsible for all charges incurred for services provided by WellnessPT Physical Therapy, P.C., including any applicable co-pays, coinsurance, and deductibles as determined by my insurance plan. I agree to verify my insurance benefits and understand that any balances not covered by insurance are my responsibility.

### **Payment Terms and Billing Procedures**

- Payment for services, including co-pays, is due at the time of service. WellnessPT Physical Therapy, P.C. accepts various forms of payment, including cash, credit card, and approved electronic payments.
- Should insurance claims be denied or if there is any remaining balance after insurance processing, I agree to make full payment within 30 days of receiving notice from WellnessPT Physical Therapy, P.C.
- A fee may be applied for returned checks, late payments, or missed appointments without proper notice.

### **Cancellation and No-Show Policy**

At WellnessPT, we strive to provide all patients with exceptional care. Timely cancellations allow us to offer appointments to other patients in need. The following policy applies to all scheduled physical therapy services, including telehealth:

- **Notice for Cancellation or Rescheduling:** Patients are required to notify WellnessPT at least 24 hours in advance if they need to cancel or reschedule their appointment. Notification can be made via phone, email, or patient portal during business hours.
- **Cancellation Fee:** A cancellation fee of \$50 will be charged to patients who cancel or reschedule less than 24 hours before their appointment. This fee must be paid before the next appointment.
- **No-Show Policy:** Patients who fail to attend a scheduled appointment without prior notice will be considered a no-show and will be charged a \$100 no-show fee. Repeated no-shows may lead to a reevaluation of the care plan and potential discharge from the practice.
- **Exceptions:** We understand that emergencies and unforeseen circumstances may arise. Exceptions to this policy may be made at the discretion of WellnessPT on a case-by-case basis.
- **Insurance:** Please note that insurance does not cover cancellation or no-show fees; these fees are the responsibility of the patient.

**Authorization for Payment and Assignment of Benefits**

I authorize WellnessPT Physical Therapy, P.C. to bill my insurance carrier directly and to receive payment for services rendered. I understand that I am ultimately responsible for any charges not covered by my insurance, including non-covered services or out-of-network charges.

**Policy Acknowledgment**

I acknowledge and agree to abide by the terms outlined in this Financial Consent, Payment, and Cancellation Policy. I understand my financial responsibilities and agree to the terms regarding cancellations and no-shows, including the payment of any applicable fees.

**Patient's Name/Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_