Patient Attendance Policy

It is the policy of *Advanced Orthopaedics and Rehabilitation, LLC* to deliver prompt courteous service to all of our patients. In order for us to deliver service in this manner, we schedule individual appointments. We schedule these appointments so that they are convenient to you. It is important for you to arrange your schedule so that you can be available and on time for this personalized appointment.

If you are unable to attend or will be late for your scheduled appointment, please notify the Rehab receptionist in advance. If necessary, at that time you can reschedule the missed appointment; failure to reschedule therapy appoint times may hinder your recovery process. By notifying *Advanced Orthopaedics and Rehabilitation, LLC* in advanced that you are unable to keep the appointment (or will be late) we are able to arrange our schedules to accommodate you as well as other patients. We urge you to call 24 hours prior to your scheduled appointment if you will need to cancel your appointment.

If you do not attend or cancel three consecutive appointments, please understand that you may be discharged at the discretion of the treating clinician.

If you are covered by workers compensation insurance and you fail to keep the scheduled appointments that are recommended to you by your therapist and your physician, the appropriate parties will need to be notified of your absence. That was include your physician, insurance company, and case manager/rehabilitation nurse. Please understand that failure to actively participate in the rehabilitation program may have a negative affect of your worker's compensation coverage.

I have read and understand the above. I understand that attendance at each therapy session is important to my recovery and will notify *Advanced Orthopaedics and Rehabilitation, LLC* if I am unable to attend in enough time to allow for rescheduling.

Patient Signature:_____ Date:_____

OR

Parent/Guardian Signature:_____ Date:_____

Patient Name: _____ Date: _____

Many insurance companies combine benefits for Physical Therapy, Occupational Therapy and Chiropractic care into one category with a pre-set number of authorized visits. In order for ***Advanced Orthopaedics and Rehabilitation, LLC*** to obtain the most accurate benefit information (benefit verification), you will need to notify us of any Physical, Occupational, or Chiropractic visits that you have attended this calendar year.

Have you received Physical, Occupational Therapy or Chiropractic treatments this calendar year? _____ If "***YES***" please indicate the number of visits that you have attended._____

Are you currently receiving Home Health services? _____

If you are currently receiving Home Health Services please inform the receptionist.

It is your responsibility to know your insurance plan coverage for Physical, Occupational Therapy services. You will be held responsible for all unpaid balances on your account. ***Advanced Orthopaedics and Rehabilitation, LLC*** *will not be held responsible for any unpaid amount not paid by you insurance company.* ***We highly encourage you to call your insurance company for more information about the benefits of your plan.*** This includes, but is not limited to, additional co-pays per procedure. This may result an outstanding balance for therapy services.

In order for ***Advanced Orthopaedics and Rehabilitation, LLC*** to submit a claim for payment to us for services covered under you policy, we must have your authorization to release medical information to you insurance carrier.

I, _____ hereby authorize ***Advanced Orthopaedics and Rehabilitation, LLC*** to submit a claim to my insurance carrier, or its intermediaries, for all services rendered and authorized, as well as direct my insurance carrier, or its intermediaries, to issue payment(s) directly to ***Advanced Orthopaedics and Rehabilitation, LLC***

Financial Responsibility:

I, _____ understand that I am financially responsible for, and will be billed by ***Advanced Orthopaedics and Rehabilitation, LLC*** and balances that are unpaid on my account which are unpaid by my insurance carrier, i.e., co-payments, co-insurance, and deductibles not met.

Consent to Treat:

I, _____ understand that I have been referred to ***Advanced Orthopaedics and Rehabilitation, LLC*** for treatment and care. ***Advanced Orthopaedics and Rehabilitation, LLC*** has described for me my individual treatment plan. I understand that I have the right to have any questions answered prior to receiving any treatment including any risks or alternatives to treatment plan that has been prescribed for me. I am also aware that there may be similar programs available to me and that I am in no way obligated to attend ***Advanced Orthopaedics and Rehabilitation, LLC*** for my rehabilitation. By signing this agreement, I consent to have ***Advanced Orthopaedics and Rehabilitation, LLC*** provide treatment as prescribed by my physician and/or recommended by my therapist.

Patient Signature: _____