

Carling Aquatic & Physical Therapy

725 West Elliot Road, Suite 103
Gilbert, Arizona 85233

Welcome to Carling Aquatic and Physical Therapy! We respect your time and would like to make your visit to our office as efficient as possible. Please review the following information regarding your physical therapy care. **PLEASE READ CAREFULLY.**

Arrival: Please arrive on time for all appointments. If you are going to be late please call. If you are more than 15 minutes late you may be asked to reschedule your appointment or your treatment may be modified. Initial _____

Scheduling: Please schedule your next appointment(s) *before* you leave. Initial _____

Cancellation: If you are unable to attend a treatment session, please notify us at least 24 hours prior to your appointment time. Failure to do so will result in a \$10 fee not covered by your insurance. Initial _____

Compliance: If you do not show for an appointment and/or do not call before the appointment to cancel and reschedule, it will be considered a no show. We reserve the right to discontinue your therapy if you have two no shows or three cancellations within 3 weeks. Please note that workers' compensation laws require us to inform the employer and carrier of any non-compliance issues. Special circumstances will always be taken into consideration, but remember that your attendance is very important to your recovery. Initial _____

Authorization for treatment, Assignment of insurance benefits, Guarantee of payment, Release of records:

I agree and give my consent for Carling Aquatic and Physical Therapy, LLC to furnish medical care and treatment to me considered necessary and proper in diagnosing and treating my physical and mental condition.

I authorize the release/transfer of all records regarding treatment to all agencies concerned in this case.

I hereby guarantee payment of all charges incurred for my course of treatment. I understand that I must pay any copay, coinsurance, or deductible due at the time of service. While I understand Carling Physical Therapy will verify my benefits, I agree that it is ultimately my responsibility to know what is covered or not covered under my insurance plan. I further agree to pay, upon receipt, any bill for services or products not covered by my insurance company. In addition, if my insurance company does not provide payment within 90 days from the date of service, and a reasonable attempt has been made by the staff of Carling Physical Therapy to collect payment from them, then I will be billed for the services. I further understand that upon referral to a collection agency or attorney, I will be responsible for all costs of collecting moneys owed, including court costs, collections fees and attorney fees.

Patient/Guardian Signature

Date