DREAM
PHYSICAL THERAPY
FEELS LIKE A DREAM
ONLY WITH REAL RESULTS

Dream Physical Therapy
43-34 32nd Place, Penthouse
Long Island City, New York 11101
212-500-0560

DREAM PHYSICAL THERAPY PATIENT AGREEMENT

Thank you for choosing Dream Physical Therapy for your rehabilitation needs. Please read and sign the following agreement; it lays out our billing, scheduling, and cancellation procedures. If you have any questions please ask for clarification.

- All patients attending physical therapy must have a valid, written prescription by a medical doctor, osteopath or podiatrist (a Prescription is needed after the first 10 visits or 30 days, whichever comes first). Patients are responsible for scheduling and confirming appointments with our front desk staff.

- Payment of all fees is expected at time of service or via credit card on file. We will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payment or any claims denied by your insurance carrier.

- I hereby authorize payment of medical benefits directly to Dream Physical Therapy for all services rendered.

- I here authorize Dream Physical Therapy, having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. *I understand that if at any point my insurance coverage changes, I am to notify administrative staff prior to my next visit. Failure to do so will result in me being responsible for the full amount of services.*

- **A scheduled appointment must be cancelled at least 12 hours in advance or a Late Cancel Fee of $50 will be assessed. Similarly, if you do not show up for a scheduled appointment a $50 fee will be assessed. This fee is due on the next visit and is not billable to any insurance carrier.**

- In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to Dream Physical Therapy all rights, title, and interest in the benefits payable for services rendered by Dream Physical Therapy provided by my insurance policy. I hereby authorize my insurance carrier to pay direct to Dream Physical Therapy all benefits due under the policy. If Dream Physical Therapy is unable to collect payments for services rendered herein or if I fail to forward any and all monies received by me from my insurance carrier for rendered services to Dream Physical Therapy and they must use a collection agency, I will be responsible for all collection and/or attorney's fees incurred, in addition to interest accruing from the date of service. A photo static copy of this authorization shall be considered effective and as valid as the original contract.

I HAVE READ AND UNDERSTOOD THIS AGREEMENT.

PATIENT NAME:

PATIENT / GUARDIAN SIGNATURE:

DATE: