

Garden Ridge Physical Therapy & Wellness Center, P.C.

Missed Appointment Policy

Thank you for choosing Garden Ridge Physical Therapy & Wellness Center, P.C., as your physical therapy provider. In order to provide you with the best optimal care, we request that you follow our guidelines regarding missed and/or cancelled appointments. Please remember that we have reserved appointment times for you. Therefore, we request at least a 24-hour notice in order to reschedule your appointment.

Release of Information

You authorize the release of any information to the physician who referred you, by telephone or in writing, the following: reports of diagnosis, treatment prognosis, recommendations, benefits payable, and any other information pertaining to your treatment at Garden Ridge Physical Therapy & Wellness Center. The same information may be released to any organization responsible for payment of your account. You also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Valuables

Garden Ridge Physical Therapy and Wellness Center is not responsible for valuables and personal property brought to the facility.

Consent for Treatment

You consent to such treatment procedures and patient care which, in the judgment of your therapist and/or physician, may be considered necessary or advisable while you are a patient of Garden Ridge Physical Therapy and Wellness Center.

Changes in Coverage

It is your responsibility to inform us of any changes of insurance coverage during your treatment. Failure to do so may result in denial of coverage by your insurance company, leaving you responsible for payment of services.

Assignment of Insurance Benefits

If necessary, you should instruct your insurance carrier to pay for services by check, made out and mailed to:

Garden Ridge Physical Therapy,
18945 FM 2252 Ste 107
Garden Ridge, TX 78266

THIS IS A DIRECT ASSIGNMENT OF YOUR RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed your indebtedness to Garden Ridge Physical Therapy, and you have agreed to pay any balance over and above this insurance payment in accordance with your current policy guidelines.

I, _____, authorize the release of my information from Garden Ridge Physical Therapy for purposes stated above.

Signature: _____ **Date:** _____