Admission Consent/ Attendance Policy/ Insurance/ Prescriptions

Consent to Treatment: I consent to rehabilitation and identical medical services at Atlantic Rehabilitation, Inc.

Liability: I know and agree that Atlantic Rehabilitation, Inc. is not responsible for loss or damage to personal values

Attendance Policy: You have been referred to physical therapy due to a physical problem or disability. The maximal benefits of therapy can only be achieved if you are serious about your rehabilitation and follow the instructions you are given.

Attendance at therapy is mandatory unless severe circumstances (illness, etc.) prevent you from making your appointment. In the event that you must cancel, please call our office 24 hours in advance and we will reschedule the appointment. If you do not show for a scheduled appointment it is your responsibility to reschedule the appointment at your next visit or by telephone. **If you miss more than 3 appointments, you will be charged $20 for each no show appointment. In the unlikely event that 3 consecutive appointments are missed, you will be automatically discharged due to non-compliance, your physician and/or insurance representative will be notified, and a new referral/prescription will be necessary to return.**

Insurance: We verify your insurance in advance as a courtesy; however, this is in no way guaranty of coverage at the time of services. Ultimately, it is the patient's responsibility to confirm coverage and all necessary documentation has been received by your insurance provider.

Should your account become delinquent, you may be turned over to collections and will be liable for any additional collection costs, attorney fees and court costs.

Prescriptions: It is your responsibility to notify us of your next doctor appointment and please do so a couple days before so we can provide the doctor with updated notes. As a courtesy we keep track of prescriptions expiration dates but it is your responsibility to obtain a new one once expired.

I HAVE READ AND UNDERSTAND THE ABOVE.

Patient Signature: ____________________________________ Date: ________________

Parent/Legal Guardian: ________________________________ Date: _______________

(if the patient is a minor, or legally incapacitated please obtain the signature of a parent or legal guardian)