Cancellation and Payment Policy

CANCELLATION POLICY

I understand that if I need to reschedule or cancel my appointment with Back @ Work Physical Therapy, I MUST do so at least one business prior to the scheduled appointment. This policy is in effect out of consideration for the staff at Back @ Work Physical Therapy, as well as other patients. **Please be advised that failure to cancel/reschedule an appointment one business day in advance will result in a $25 cancellation fee that must be paid before further treatment is performed.** By signing below you are agreeing to abide by this cancellation policy and to take personal financial responsibility for the cancellation fee should you violate this agreement.

PAYMENT POLICY

As a service to you we will call your insurance company regarding your benefits for treatment and will communicate this to you before your first visit. We encourage you to call your insurance company as well to make sure you are clear as to what services are covered. Back@Work Physical Therapy is not financially responsible for misleading or incorrect information provided by your insurance company. Back@Work Physical Therapy collects all known co-pay, coinsurance, deductible, cash pay and non-covered services or equipment charges at the time of your visit. All charges that are not covered by your insurance company will be your responsibility. For your convenience we take cash, personal checks, debit and credit card payments. Coinsurance amounts are an estimate of the amount you owe based on your specific insurance plan. If a personal check is returned for non-payment you will be charged $25 to cover bank fees associated with the returned check. We provide payment plans when necessary to ensure you have access to the treatment services you need. If you would like to know more about a payment plan please ask a staff member. If your insurance is a worker compensation or automobile insurance claim we will invoice the insurance company. If the worker compensation/auto insurance claim is denied, you will be responsible for the cost of the treatments.

I the undersigned agree to pay interest at the rate of 18% annually on all balances, past present and future, over 90 days from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the outstanding balance.

I have read and thoroughly understand and agree to the above policies and conditions. I am voluntarily signing and acknowledging my knowledge of these policies

_____	_____	_____
Patient Name (PRINT)	Client Signature	Date

LOGAN CLINIC
1202 South Hwy 89, Ste 110
Logan, Utah 84321
Office: 435-213-3850
Fax:

BACK @ WORK
PHYSICAL THERAPY

LAYTON CLINIC
1550 North Main St., Ste C
Layton, Utah 84041
Office: 801-217-3755
Fax: 801-217-3180