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Westcott Physical Therapy Policies

PAYMENT POLICY

Insured patients who have a co-pay or patients paying out-of-pocket are **required to pay at each visit.** We accept cash, checks, Visa, MasterCard, Discover and American Express. There will be a $25 fee for all returned checks.

DELINQUENT PAYMENT POLICY

Once it has been determined by your insurance company that you are responsible for any amount of the total charge, we will send you an invoice for that amount. It is expected that you will make every effort to pay in a timely manner. If payment is not received within 90 days from the date of the original invoice, the "Collections" process will begin. If you have any questions about the invoice or have any difficulties paying the amount please do not hesitate to call our office so we can discuss that with you.

CANCELLATION & PUNCTUALITY POLICY

We enforce a 24-hour cancellation policy. That means **if you cancel an appointment with less than 24-hours notice, a $75 fee will be assessed for the appointment missed**. We understand that emergencies do arise in life. For all other instances, we require 24-hour notice as a simple and basic courtesy. We have an extensive waitlist that we need to accommodate when possible. This policy is in place so that we can best serve the needs of all our patients.

Our priority is to spend quality time with our patients. In order to accomplish this, we schedule the appropriate time needed for each person and do not overbook, overlap, or "squeeze in" extra patients during your time. Therefore, **late arrival of a patient will result in a shortened treatment time or cancellation**. The patient will still be responsible for payment.

SICK POLICY

Because many of our patients have compromised immunity, a patient must be fever-free or diarrhea-free, without the use of medications, for 24 hours prior to their schedule appointment. We ask that you inform us of illness via phone or email and recover at home. You will not be charged for your missed visit.

I have read and understand the Westcott Physical Therapy policies stated above.

_____ _____

Patient's PRINTED Name Date

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Patient's Signature (Parent/Legal Guardian if under 18 years old)