**Ability Physical Therapy PLLC**
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**AbilityPT@icloud.com**

**1225 Birch St Suite B**
**P.O. Box 4181**
**Helena, MT 59604**
**Web: Abilitypt.org**

Please initial to the left as an indication of agreement and sign and date the bottom.

**1. Missed Appointment Policy:**

_____ Please make all efforts to keep your child's appointment. If you are unable to make your appointment, please contact Ability Physical Therapy PLLC and cancel. A 24- hour notice is preferred for cancellations. Should you miss an appointment without 24-hour notice of cancellation, you may be charged a $25 fee.
If 3 appointments are missed due to no-show or cancellation without 24-hour notice, your child's physical therapy program may be suspended.
It is understood that there are emergencies and sicknesses often occur last minute. We at Ability Physical Therapy PLLC do not want to expose illness to other families, ourselves, or our own children. Please be respectful and cancel your appointment if your child is sick or has any of the following symptoms: vomiting, fever 100° or over, diarrhea, sore throat, rash, or red/runny eyes. You will not be charged a fee for a cancellation due to sickness.

**2. Payment Policy:**

_____ I agree to pay Ability Physical Therapy PLLC for the services provided to my child/dependent. If any laws or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. When the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

**3. Financial Policy:**

_____ Insurance benefits are verified by Ability Physical Therapy PLLC before the start of services as a courtesy to you. We strive to obtain accurate information, but the quoted benefits from your insurance company are not a guarantee of payment. It is your responsibility to check your benefits and get information regarding your coverage from your insurance company. You are responsible for insurance co-payments/co-insurance and supplies at the time of service. In the event we receive a denial for payment from your insurance company and you chose to continue with therapy, payment for services are due at the time of service. If payment is not received from your insurance company within 60 days from the date of filing, you will be responsible for payment in full. There is a $25 fee for returned checks. You are financially responsible for payment of services rendered.
By initialing above, you acknowledge that you understand that you are financially responsible to Ability Physical Therapy PLLC for any changes incurred during the course of treatment, and you understand and agree to the financial policy explained herein.

**4. Recording and Photography**

_____ The use of recording and photography can be used as an adjunct to evaluation, assessment, and treatment. The information captured is used solely for the purposes of documentation and/or assessment of progress. Ability Physical Therapy PLLC will protect all videos and photographs and will follow all confidentiality rules for our patients. If recordings are taken, after reviewing the recording and using it as mentioned above, the data will be deleted. By initialing above, you agree to allow your dependent to be recorded or photographed.

_____ _____
Guardian's Signature Date