REBOUND
HAWAII
Physical Therapy & Massage Therapy

ATTENDANCE POLICY

Regular and consistent attendance allows for optimal success with your physical therapy program. Your referring physician and physical therapist recommends following your prescription for the best possible recovery.

If for any unforeseen reason you must cancel an appointment, ***please contact our office at least 24 hours in advance*** to reschedule your appointment. A ***$25 charge will be assessed if you DO NOT show up for your appointment and/or on the 2nd consecutive cancellation without a 24- hour notice.*** This fee is not covered by insurance and is payable prior to your next scheduled visit.

Excessive cancellation and no show appointments will require a return to your physician for an updated prescription. 2 consecutive cancellations without a 24-hour notice and/or no-show appointments will result in an automatic discharge.

USE OF INSURANCE BENEFITS

Every insurance plan varies in the amounts and type of medical coverage offered. If you do not understand your benefits, please contact your insurance company. If your insurance company does not cover our services in full, you will be responsible for the remaining amount.

If your insurance plan dictates that you are responsible for an annual deductible and/or copay for services rendered, please make your payment at the time of service. For any plans that require a percentage of eligible charges, estimated payments will be accepted. If you are unable to meet your financial obligations, please contact our billing department for a payment plan.

CO-PAYMENT/CO-PERCENTAGE

Please note, if your insurance policy has a deductible and it has **NOT** been met, you will be responsible for payments that fulfill the minimum deductible. State tax **MAY NOT** be covered by insurance.

Co-pay per visit: $_____

Co-percentage per visit: _____ % of eligible charges. Estimated co-percentage amount $ _____

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By signing below, I am acknowledging that I have been informed of the Rebound Hawaii attendance and co-pay policies and agree to adhere to the above mentioned policies.

Name of patient (Print): _____ Signed:_____

Parent/Guardian Name: _____Signed:_____

Date: _____

(Rev. 6/26/17)