NOTICE OF ADVICE

To all patients being seen without a prescription:
Please be advised that you will be financially responsible for all treatments that are not covered by your insurance carrier**. The Therapy SPOT, PLLC recommends that you request a prescription from your primary or referring physician**, even if the physician says a prescription is not necessary. If you do not receive a prescription and your insurance carrier denies payments, you are responsible for any and all expenses.

Patient Name (please print):______________________________

Patient Signature: ____________________________________ Date: _____________

FINANCIAL AGREEMENT

I understand that if __________________________________ denies me payment for
(name of insurance company)
(**please circle:** PHYSICAL, OCCUPATIONAL, SPEECH) therapy treatments, I agree to pay The Therapy SPOT,PLLC for any and all of my unpaid treatments at regular rates until such time that my insurance company gives me authorization for payment.
Our regular rates are:
Initial Evaluation - $150.00
½ hour treatment - $70.00

Signature of Responsible Party : __________________________ Date: _____________

24 Hour Appointment Cancellation Policy

The Therapy SPOT for Pediatric and Adult Speech, Physical and Occupational Therapy, PLLC has a 24 hour cancellation / rescheduling policy. **If you miss or cancel your appointment with less than 24 hours notice, you will be charged a fee of $50**. No cancellation fee will be charged if the missed appointment is rescheduled within 2 weeks. Cancellation and No Show fees will be due prior to receiving or scheduling future appointments.
This policy is in place out of respect for our therapists and our clients. By providing us with appropriate notice, we can provide the time slot originally reserved for you to another person in need.
By signing below, you acknowledge that you have read, understand and agree to abide by the Cancellation Policy for The Therapy SPOT, PLLC as described above.
Thank you for your understanding and cooperation.

Signature of Responsible Party : __________________________ Date: _____________