



Cancellation Policy

A minimum of 24-hours notice of cancellation is required for all appointments. Please note: Monday appointments must be canceled prior to 7am that day, you may leave a message on the answering machine over the weekend.

- ☐ I acknowledge that a \$25 missed appointment charge, non-refundable and non-billable to insurance will be charged to me, if I do not comply
- ☐ I acknowledge that if I have two or more instances of no-shows or less than 24-hour cancellation notice, I may have future appointments removed from the schedule and/or be discharged

Copayments, Deductibles and Unpaid Balances

- ☐ I acknowledge that copayments are due at the beginning of each visit
- ☐ I acknowledge that I am responsible for any deductible and unpaid balance by my insurer for the services rendered by Holmes Physical Therapy
- ☐ I acknowledge that it is my responsibility to promptly notify Holmes Physical Therapy of any changes and to maintain accurate coordination of benefits information with my insurance carrier. If I fail to do so and my insurance cannot be billed or denies payment due to expired timely filing limits or incomplete information, I agree to pay the full charges for services rendered.

Referral Policy

Referrals, if required by your insurance are the responsibility of the patient and are required to be received by our office prior to the initial visit.

- ☐ I understand that referrals are my responsibility and can be obtained through my Primary Care Physician

Notice of Privacy Practices

- ☐ I acknowledge that I have seen the "Notice of Information Practices" and HIPAA compliance form

Consent for Treatment / Informed Consent

- ☐ I hereby give my voluntary, written consent to receive evaluation and treatment by qualified physical therapists or authorized staff of Holmes Physical Therapy.
- ☐ I understand that my provider may use an AI-powered documentation assistant that listens to our visit to help create clinical notes. The AI assistant supports documentation only. My provider reviews and edits all notes and it does not replace clinical judgement. I understand that I may decline or withdraw my consent at any time during a visit without affecting my treatment.

Name: _____

Date: _____

Signature: _____