

| **Bonne Terre**  **55 Nesbit Drive**  **Bonne Terre, MO 63628**  **P:  573-358-9553**  **F:  844-815-1320** | **Crystal City**  **2308 N Truman Blvd**  **Crystal City, MO 63019**  **P: 636-206-6070**  **F: 833-579-2992** | **Ste. Genevieve**  **60 Plaza Drive**  **Ste. Genevieve, MO 63670**  **P:  573-608-5058**  **F:  844-912-8618** | **Owensville**  **603 E Hwy 28**  **Owensville, MO 65066**  **P:  636-649-5530**  **F:  833-278-7377** |
| --- | --- | --- | --- |

**Policy Reminder Form**

Thank you for choosing Potential Therapy Services for your physical therapy needs. To ensure smooth communication and proper handling of billing, we kindly ask all patients to acknowledge and agree to the following policy:

### Insurance Information Policy: Patient Responsibility: It is the responsibility of each patient to inform our clinic of any changes to their insurance information before or at the time of their appointment.

1. **Notification Requirement**: Updates to insurance coverage, new insurance policies, or changes to existing insurance plans must be provided promptly. Failure to notify us of such changes may result in incorrect billing.
2. **Financial Responsibility**: In the event that a patient does not inform us of insurance changes, they will be held responsible for any charges incurred due to billing errors or claims denials.

### Cancellation Policy To better serve our patients and manage our waitlist effectively, we are enforcing a 24-hour cancellation policy. Any appointment not canceled at least 24 hours in advance will incur a cancellation fee of $25. This policy will be strictly enforced.

By signing below, you acknowledge that you have read, understand, and agree to the terms outlined in this policy. You also confirm that you will notify the clinic promptly of any changes to your insurance information and adhere to the cancellation policy.

**Patient Acknowledgment**

I have read and understood the Insurance Information Policy and Cancellation Policy above. I agree to provide updated insurance information as required and accept financial responsibility for charges incurred due to failure to notify the clinic of changes or failure to cancel appointments within the required time frame.

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_