316 W. Spruce St ● Missoula, MT 59802-4108 ● P 406-541-9500 ● F 406-541-9501

Patient Name (Last, First, MI) _____ Date _____

Cancellation/Missed Appointment Policy

If it is necessary that you cancel or change your appointment time, **we require that you do so at least 24 hours in advance to your scheduled appointment.** Calling earlier is greatly appreciated. Your cancellation will give another patient the possibility to have access to timely medical care. Failure to cancel or reschedule your appointment at least 24 hours in advance can result in a **$20.00 Fee.**

Non-cancelled appointments that are missed are considered a **"No-Show".** Failure to show up to a scheduled appointment will be recorded in the patients chart and can result in a **$40.00 fee.**

Big Sky Physical Therapy respects your time and appreciates your respect of ours in return. **Please be on time** for your appointment, this will help keep everything flowing nicely and help keep us on schedule so that everyone is seen in a timely manner. **If you are more than 20 minutes late for your scheduled appointment we will have to assume that you are a "No-Show"** and you can be charged a **$40.00 fee.**

By signing this document you are showing that you agree to the above policy and agree to pay fees for any failure to promptly cancel your appointment or show up for your appointment on time.

_____
Initials

Authorization and Medical Benefits Assignment

Big Sky Physical Therapy has permission to release to third party payors requested medical and/or other information necessary to process patient's claim(s). Assignment is hereby given to Big Sky Physical Therapy, PLLC for all benefits which are or shall become payable from any third party payor who is responsible for payment of patient's Big Sky Physical Therapy, PLLC, expenses. Authorization and direction is given to all third party payors to pay all benefits directly to Big Sky Physical Therapy, PLLC,

Patient and/or Person(s) legally and financially responsible for patient's medical bill agree to pay patient's account regardless of the existence of insurance or other third party liability. Full payment will be made promptly unless other credit arrangements are made. Big Sky Physical Therapy, PLLC is free to declare the entire balance to be due and payable if any scheduled payment is missed. The undersigned agrees to all costs of collection, including reasonable attorney's fees, if the account is not paid in a timely manner.

Authorization is given for treatment of the above named individual and agreement is made to pay fees and charges for any services received by the patient listed above.

_____ _____
Signature of Patient or Patient Representative Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient