Dedham Health Physical Therapy (DRAC PT Inc.)
https://dedhamhealthphysicaltherapy.com/
200 Providence Highway
Dedham, MA 02026

P: 781-326-8332
F: 781-326-8262

COPAY, DEDUCTIBLE AND CO-INSURANCE AGREEMENTS:

DRAC Physical Therapy reserves the right to reschedule my appointment due to outstanding balances.

I hereby agree to pay all the deductible and co-insurance payments if required by the policies of my insurance coverage. I further agree to pay these bills upon notification. Failure to comply with reimbursement of all balances owed may lead to collection activity.

PREVIOUS TREATMENT:

I understand it is my responsibility to inform staff at DRAC Physical Therapy if I have received medical treatment elsewhere for the same or any other injuries because I might have used part of, if not all, of my insurance benefits. It is also my responsibility to find out the availability of my Physical Therapy benefit from my insurance company if I have been treated for the same or other injuries before. By not providing this important information, I will be held responsible for any/all claims denied by my insurance due to benefit exhaustion.

RELEASE OF MEDICAL RECORDS:

I hereby consent to the release of any and all records, information, or copies related to my physician, nurse case manager, rehabilitation specialist, insurance company or attorney when appropriate. I also understand that regular reports will be provided to them as requested and as they relate to my treatment and progress.

PRIVACY NOTICE:

Dedham Health's Privacy Policy is posted in our lobby and also included at the end of this packet. If you would like to receive Dedham Health's Privacy Notice, please ask reception for a copy.

TREATING THERAPIST:

I understand that after my evaluation today my appointments may be scheduled with another therapist. We would like to apologize for any inconvenience this may cause to you.

NO SHOW/CANCELLATION POLICY AGREEMENT:

I understand any appointment I schedule and do not attend **OR** schedule and do not cancel within 24 hours may be subject to a $35 no show fee which **MUST** be paid before my next appointment.

By signing below, I acknowledge that I have agreed to the above mentioned policies, and consent for DRAC Physical Therapy, INC. to render treatment.

Patient Signature:_____ **Date:**_____

HOW DID YOU HEAR ABOUT US?

☐ **AD/NEWSLETTER** ☐ **FACEBOOK** ☐ **INSTAGRAM** ☐ **FRIEND/FAMILY** ☐ **DOCTOR** ☐ **OTHER:**_____