RELEASE OF INFORMATION

I authorize **Greater Brunswick Physical Therapy** to release information regarding my care to those companies and/or individuals listed below unless otherwise indicated. This information may be in the form of typed or written notes, faxed information, billing information, or verbal discussions. (Please note: Number 1-4 is required if billing your physical therapy treatments to your insurance company.)

1. My Referring Physician
2. My Primary Care Physician (if different)
3. My Insurance Carrier (s)
4. My Electronic Billing Clearing House
5. My Attorney's Office (Name) ____________________
6. Others: ____________________

   ____

Signature:____________________ Date:__________

I authorize Greater Brunswick Physical Therapy to discuss my scheduling of appointments at Greater Brunswick Physical Therapy with the following individuals:

____

____

May leave a message on my answering machine? ___Yes/___No

Signature____________________ Date__________

CANCELLATION/NO-SHOW POLICY

Our cancellation/no-show policy is designed to improve the quality of care of our present patients and allow us to see new patients who need our services. Any combination of four cancellations and/or no-shows will result in discharge from physical therapy. Your physician will be contacted to inform him/her of the reason for discharge. Additionally, if more than one appointment is missed due to no-shows, a **$30.00** fee will be charged for each subequent no-show. **This fee is not covered by insurance.**

I have read and understand the above policy ____________________

Signature/Date