Lalla S McHugh PT
P: 781-519-4756
F: 781-519-4757

Thank you for choosing me as your physical therapist. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is my company statement regarding your privacy and billing. Please read and sign prior to starting your program.

INSURANCE BILLING PROCEDURES

- As a courtesy to you, the patient, your insurance company will be billed directly upon your authorization. To do so, a call may be made to verify your insurance coverage. However, this is not always a guarantee of payment.
- Most insurance plans cover a percentage of physical therapy and you, the patient, are responsible for the remaining percentage or co-payment.
- Please inform me if you have a deductible so that we may determine if this has been fully met, and to work together on a suitable payment plan if your deductible has not been met.
- As patient or parent, you are fully responsible for payment of your treatments; and payments from the insurance carrier will be credited to that account.
- If you choose not to assign insurance benefits to me, the full amount is due at the time of service (cash or check only).
- Copayments are due at the time of treatment via check or cash. I cannot accept credit cards or HSA cards, but am glad to provide you with a receipt of payment that you may submit for reimbursement.
- Please make checks payable to Lalla S McHugh.

CANCELLATION POLICY

24 HOUR CANCELLATION NOTICE IS REQUIRED. As you may know, the schedule is very busy so please give at least 24 hour notice of a cancellation. You will be charged a $100 charge for no shows or cancellations without proper notification. If you are seriously ill on the day of treatment please call to cancel; this will be taken into account.

PRIVACY POLICY

As a patient in this office you may have access to all of your medical records that we have and they are maintained in such a manner to respect your privacy completely. No personal information will be shared with any other clinicians or persons without your authorization. Contact will be made with your insurance company and your referring physicians as listed on your patient information form, only with your signature below. If you have any concerns or questions regarding your privacy please ask at any point.

BENEFIT ASSIGNMENT AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize the release of medical and non medical information to my insurance carrier that may be necessary to process my claim. I authorize release of physical therapy notes to the physicians listed on my intake form, if needed. I have read and agree with the privacy policies of this office. I hereby authorize payment directly to this practice for the physical therapy services provided. I agree that if my insurance carrier does not pay for the services rendered unto me in full, I will be responsible to make full payment within 20 days of receipt of a statement for said services. In the event that it is necessary to refer this account, I agree to pay all costs of collection including, but not limited to, reasonable attorney fees, court costs, and interest permitted by law.
I understand and acknowledge responsibility for all information contained in this document.

_____ _____ _____

Patient signature | Parent/guardian (if patient under 18 years | Date