Contract for Physical Therapy Services

I, the parent/guarantor, understand that I am fully responsible for the payment of my child’s physical therapy sessions. I understand that payment is due in full upon delivery of service. I will be provided with a service invoice containing the necessary information so that I can bill my insurance company directly.

Furthermore, I understand that payment under this contract is not contingent upon reimbursement by any insurance company.

I understand the therapist requires that during the time services are being provided, a responsible person should be present. This party must have the authority to make any emergency medical decisions.

I understand the therapist requires a minimum of 48 hours notice if my child is not available for his/her scheduled therapy session. Without 48 hours notice the session will be billed at the regular rate.

By my signature below, I acknowledge that I fully understand and consent to the above terms.

Child’s Name: .................................................................

Parent’s Signature: ............................................................

Date: ..............................................................................