**MAIN PHONE**
(310) 539-8800

**MAIN FAX**
(310) 698-5410

INDEPENDENT PHYSICAL THERAPY

**TORRANCE/MAIN MAILING**
2355 CRENSHAW BLVD.SUITE 130
TORRANCE, CA 90501

**ENCINO/SHERMAN OAKS**
15720 VENTURA BLVD. # 100
ENCINO, CA 91436

www.independentphysicaltherapy.com

**PALOS VERDES**
501 DEEP VALLEY DR. #200
ROLLING HILLS, CA 90274

**CARSON**
559 E. CARSON ST. #B
CARSON, CA 90745

**Culver City**
5601 WEST SLAUSON AVE. UNIT 125
CULVER CITY, CA 90230

**HERMOSA BEACH**
1601 PACIFIC COAST HWY., # 165
HERMOSA BEACH, CA 90254

**U.C.L.A**
1060 GLENDON AVE.
LOS ANGELES, CA 90024

Dear patient:

Thank you for choosing INDEPENDENT PHYSICAL THERAPY (IPT) to provide their care in therapy. Below explains our office policies and financial responsibility for the services provided to you by IPT. We have great care and pride in their therapy. **We ask you to please give us 24 hours notice if you need to cancel an appointment. IPT reserves the right to charge a fee of $35 for the appointments lost without 24 hours notice.**

You may not be covered by your insurance company for the following reasons:

1. You may not be eligible at the time of the service (s).
2. These services may have not been allowed.
3. You did not provide a prescription for physical therapy from a physician required by your insurance. and/or your services were not considered medically necessary.
4. These services may not be covered under your plan.
5. Deductible may not have been met.
6. The insurance carrier may fail to reimburse within the contracted time of 60 days.

**Patient Agreement**:

1. I certify that I have read and understood the above information. I have advised INDEPENDENT PHYSICAL THERAPY to proceed with today's services whether they are or are not covered by my insurance.
2. My consent for treatment is hereby authorized.
3. I hereby assign all medical benefits Payable to : INDEPENDENT PHYSICAL THERAPY
4. I understand that if I have a co-pay responsibility it is due at the time of service.
5. I understand co-insurance, deductibles and all outstanding balances are due upon receipt. If payment is not received within 30 days, ***my credit card will be charged for the amount owed***.
6. I understand that it is ***my responsibility*** to know and understand what my insurance policy covers and what it does not cover, and know that I meet the requirements at the time of any service.
7. I agree that my responsibility is to inform and provide IPT with any change to my insurance coverage.
8. I acknowledge receipt of Notice of Privacy Practices.

_____ _____ _____

Patient Name Patient Signature Date