Bertrand Chaffee Hospital
Physical Therapy Department
224 East Main St.
Springville, NY 14141

Welcome to Bertrand Chaffee's Physical Therapy Department. In an effort to meet your needs while receiving rehabilitative care, we ask that you assist us in the following:

- Any family or visitor who accompanies you should remain in the waiting room. If they would like to observe or receive training in regards to your rehab – please speak with your assigned therapist.
- Please be prompt for your scheduled appointment; notify the secretary upon your arrival.
- Please contact the department at **592-2871 x 1262,** if you are unable to attend, or will be late for a scheduled appointment. A 24-hour notice of cancellation would be appreciated. If you are consistently late, or fail to keep two consecutive appointments, therapy may be discontinued at your therapist's discretion, and with physician notification.

_____ Initial please

- **For your initial visit, a valid physician prescription is required**. An **insurance referral** from your primary physician may be necessary and it is **<u>your</u> responsibility** as the patient to obtain these referrals.
- All patients having a co-pay or co-insurance payment associated with their therapy are expected to make these payments <u>at the time services are</u> <u>rendered</u>. Payments will be taken at the Physical Therapy Reception Desk. If you have concerns about financial obligations, you are welcome to meet confidentially with Patient Accounts to assist you with options for payment. The Physical Therapy Staff can direct you to appropriate personnel.

_____ Initial please

- If you have any questions regarding your physical therapy coverage through your insurance (co-pays, referrals etc.)… please call your insurance customer service representative (phone number is on your insurance card) to assure you understand your specific insurance requirements and coverage.

Thank you…we look forward to working with you!
The Physical Therapy Staff

- I have read and understand the above and accept responsibility for these aspects of my care.

Patient Name: _____Date: _____