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Patient Privacy and Procedure Statement

Cedar Hill Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000. A notice of our privacy practices is posted in our waiting area and is available on our website, www.cedarhillpt.com. You may request a copy.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 336-644-9661.

Cedar Hill Physical Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Financial Policy Statement

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and co-insurances are to be made as services are rendered. If your medical benefits are not paid within sixty (60) days, the balance with be due in full from you.

If any payments of medical benefits are made directly to you for services rendered by Cedar Hill Physical Therapy, you must promptly remit such payment directly to Cedar Hill Physical Therapy.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is denied.

If you fail to make timely payment for any amount for which you are responsible, you will additionally be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above privacy and financial statements and/or it has been explained to me and I accept the terms and conditions. I will be responsible for the payment of my account.

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Signature of Patient or Personal Representative | Date