Cancellation/No-Show Policy
(Insurance Pay)

All cancellations need to be made 24 hours prior to your appointment. If you do not show up for your appointment or cancel within 24 hours, you will be responsible to pay for 100% of the session.

Payment Policy

Your insurance benefits will be checked and verified prior to your initial treatment and you will be notified of your out of pocket expense. Treatment will be billed under your out of network physical therapy benefits and payment for the difference in coverage based on copayment and coinsurance responsibilities, in the form of cash, check or credit card, is due at the time of each visit. Because Dr. Brown is an out of network provider your insurance may send payments directly to you the patient. Please contact our office upon receipt of payment. You will be billed the full amount charged to your insurance company until payment is remitted to Dr. Brown.

I have read and understand the above policies:

Patient Name: _____

Patient/Guardian Signature: _____

Guardian Name: _____

Date: _____

Thank you for your cooperation and business.

DR. JA'NAE BROWN, PT, DPT
& Physical Therapy San Pedro

Cancellation/No-Show Policy
(Cash Pay)

All cancellations need to be made 24 hours prior to your appointment. If you do not show up for your appointment or cancel within 24 hours, you will be responsible to pay for 100% of the session.

Payment Policy

Your initial evaluation is $175 and follow up treatment sessions are $140. Payment, in the form of cash, check or credit card, is due at the time of each visit.

We are not billing your insurance company. However, the payments you make may be reimbursable by your insurance company under your out of network physical therapy benefits; the exact percentage depends upon your plan. Due to the complex nature of insurance claims and reimbursement, we make no promises as to whether you will receive reimbursement.

We will assist you in every way possible. Payment is due at the time of service

I have read and understand the above policies:

Patient Name: _____

Patient/Guardian Signature: _____

Guardian Name: _____

Date: _____

Thank you for your cooperation and business.

DR. JA'NAE BROWN, PT, DPT
& Physical Therapy San Pedro