FYZICAL®
Therapy & Balance Centers

Patient Acknowledgement Form

Please Initial:

_____ I consent to ***evaluation and treatment*** by FYZICAL® Therapy & Balance Centers. and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ The filing of insurance claims is a ***courtesy*** that we extend to our patients. You will be ***responsible for any charges not reimbursed*** or contractually adjusted by your insurance company. Should your claims not process as you expect or should you have any questions regarding your insurance plan benefits, please contact them directly.

_____ I authorize the ***release of information*** acquired in the course of my treatment, including but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, other third party payers and/or the following (i.e. spouse, family member, friend): _____

_____ I authorize ***phone messages*** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ A copy of this facility's ***Notice of Information/ Privacy Practices*** has been provided to me.

_____ Medicare beneficiaries have an annual cap for combined therapy services including Physical, Occupational and Speech therapies.

_____ A $35.00 fee will be charged for returned checks.

_____ Should a patient account become 60 days past due, the account will be placed with a collection agency and a $35.00 collection fee will be charged.

_____ I hereby ***assign*** to FYZICAL® Therapy & Balance Centers all payment for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

_____ ***I understand I will be charged a fee of $25.00 for cancelled or missed appointments without 24-hour notice. Payment must be rendered prior to next scheduled visit.***

_____/_____ _____
Patient Signature Initials Date

_____ _____
Patient Legal Representative Date