Patient Acknowledgement Form

Please Read and Initial:

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

_____ Our billing office, Centers for Advanced ENT Care Annapolis, will handle the filling of your insurance claims. **You will be responsible for any charges not reimbursed or not contractually adjusted by your insurance company.** Should your claims not process as you expected or should you have any questions regarding your insurance plan benefits, please contact your insurance company directly.

_____ I authorize the **release of information** acquired in the course of my treatment including by 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, e-mail, and/or text messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ I have received and/or been offered a copy of this facility's **Notice of information/ Privacy Practices** has been provided to me.

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

_____ A $35.00 charge will be charged for any returned checks.

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

_____ **I understand I will be charged a fee of $50.00 for cancelled or missed appointments without 24 hour notice. Payment must be rendered prior to next scheduled visit.**

_____ _____

Patient Signature Today's Date

_____ _____

Patient Legal Representative Today's Date