Patient Acknowledgement Form

Please read each below item carefully.

1. 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.

2. The filling 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 expected or should you have any questions regarding your insurance plan benefits, please contact your insurance company directly.

3. 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, and other third party payers.

4. 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.

5. I have received and/or been offered a copy of this facility's Notice of Information/ Privacy Practices.

6. 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.

By signing below, you indicate that you have read, understand, and agree to the above statements.

____________________________________ __________________________

Patient Signature Date