RELEASE OF INFORMATION:

I hereby authorize 1st Choice FYZICAL Therapy and Balance Center, Inc. to furnish information to insurance carriers concerning illness or accident and treatments, and I hereby assign 1st Choice FYZICAL Therapy and Balance Centers, Inc. all payments for medical service rendered to my dependents or me.

I authorize the release of my medical records to the agents of 1st Choice FYZICAL Therapy and Balance Centers, Inc. and/or agents so indicated by myself.

I understand that I am financially responsible for any amounts not covered by my insurance carrier, which includes amounts applied to my deductible, co-insurance, denied services, or charges deemed over "reasonable and customary".

24 HOUR APPOINTMENT CANCELLATION POLICY: Please notify us of your cancellation within 24 hours of your appointment or there will be a $25 dollar service charge.

CONSENT FOR MEDICAL TREATMENT:

I have come to 1st Choice FYZCIAL Therapy and Balance Centers, Inc. for medical treatment and consent to the customary examinations, test, treatment, and procedures performed on patients in my condition. I understand that the practice of physical therapy is not an exact science and therefore no guarantees have been or can be made regarding the outcome of any diagnosis, treatment, test or examination performed by 1st Choice FYZICAL Therapy and Balance Center, Inc. I understand that my condition may get better, worse, or stay the same with physical therapy.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

I_____ have received the Notice of Privacy Practices from 1st Choice
Print Name
Physical Therapy, Inc.

X_____
Signature

Date_____