FYZICAL Therapy & Balance Centers

Patient Name: _____

Patient Acknowledgement Form

Please Read and Initial:

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

_____ **I understand that if I cancel and/or no show my appointment for 3 consecutive visits the FYZCIAL team reserves the right to discharge my chart from all therapy services.**

_____ 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.

_____ 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.

_____ 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.

_____ A $35.00 charge will be charged for any 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 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.**

If Patient Is A Minor

Responsible Party for bill if other than patient: _____Relationship: _____

Responsible Party's address (if other than above): _____

Date of Birth: _____ Social Security #: _____

_____ _____

Patient Signature Date

_____ _____

Patient Legal Representative Date

_____ _____

Employee Signature Date