Patient Acknowledgement Form

Please Read and Sign at Bottom of Page:

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 medical 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 Fyzical to **obtain and acquire any medical information** that would be beneficial in connection with my physical therapy services, which may include X-Rays, Cat Scans, and MRI reports along with Physician's Documentation.

I authorize Fyzical to communicate with me by **phone/voicemail/text/email,** for optimal care at our facility and also for educational purposes. You can opt out from our email list at any time.

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

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

A $50.00 fee will be charged for NO SHOW and CANCELLATIONS made less than 24 hours prior to appointment. 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.

I hereby **assign** to FYZICAL Therapy and Balance Centers all payments for medical services rendered to myself or my dependents. I hereby authorize payments to be made directly to Fyzical. **I understand I am responsible for any amount not covered by my insurance.**

Patient/Responsible Party Signature: _____Today's Date_____

FYZICAL®
Therapy & Balance Centers