Information Consent and Consent to Evaluate and Treat

Patient Information Consent

I acknowledge that I have **received/declined** a copy of the Notice of Our Privacy Practices from the office of Fyzical Therapy & Balance Centers. **Initials of Patient** _____

I understand that some of my health information may be used and/or disclosed by Fyzical Therapy & Balance Centers to carry out treatment, payment or health care operations. For a more complete description of such uses and disclosures, I should refer to your privacy notice entitled, "Notice of Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form. I understand that over time your privacy practices may need to change in accordance with the law and that if I wish to obtain a copy of this notice as revised, I can call your office to request a copy. I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations and that I can also revoke this consent in writing, but only to the extent that your practice has not taken action in reliance thereon. *I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.*

General Consent to Evaluate and Treat Please

Initial Each Item

_____ I hereby authorize Fyzical Therapy & Balance Centers to release all pertinent medical information/records requested by my insurance company(s). I hereby give consent that a copy of my medical records be sent to my primary and/or referring physician(s).

_____ I hereby authorize payment directly to Fyzical Therapy & Balance Centers, for therapy services rendered to me as specified by my insurance policy. I understand that I am financially responsible to Fyzical Therapy & Balance Centers for charges not covered by this authorization.

_____ I hereby authorize Fyzical Therapy to bill me directly for any co-insurance, co-pay or deductibles due as stated in my insurance agreement. I further agree to pay for any and all charges not covered by my insurance plan.

_____ I hereby allow Fyzical Therapy & Balance Centers to use my e-mail or mailing address to send me e-mail notices or newsletters as it pertains to physical therapy and fitness. Patient information is confidential and Fyzical will **not** give out patient mailing or e-mail addresses to any outside entity.

_____ **I understand that if electrical stimulation is included in my plan of care, it will be necessary to purchase my own electrodes for $5.00 in order to receive this treatment.** This cost is not covered by insurance, and I will be responsible for this payment.

_____ I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Fyzical Therapy & Balance Centers.

I certify that I have read and understand the above information and I am willingly submitting myself to treatment at Fyzical Therapy & Balance Centers.

Thank you for choosing Fyzical Therapy & Balance Centers for your physical therapy needs. We appreciate your business and look forward to helping you achieve your therapy goals.

Patient's Signature: _____ Date:_____

Printed Name: _____

How did you hear about us? _____

Doctors Name: _____ Phone #:_____

I permit a copy of this authorization to be used in place of the original.