FYZICAL
Therapy & Balance Centers

Patient Acknowledgement Form

Please Read and Initial:

_____ 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 filing 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, but 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 **HIPAA** privacy policy**.**

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

_____ A $50.00 fee will be charged for any returned checks.

_____ If account balance is not paid in full or a payment arrangement is not set up with our office within 30 days, a minimum finance charge of $1.50 per month, or 18% per year, will be added to the account. After 90 days, a 9% past due charge will be added to all accounts with balances over $100. If account is transferred to a collection agency or an attorney for collections, there will be a 35% fee and any attorney costs owed added to the account, in addition to the balance remaining on the account. If the desire is to remain a patient after being sent to collections, we require all services to be paid at the time of service with check, cash or credit card. In the event of the patient's account balance exceeding our carrying limit of $300, a minimum of a $50 payment will be expected. Balances will only be held for 6 months, and then will automatically be sent to collections.

_____ 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.**

_____ **I understand I will be charged a fee of $50.00 for cancelled or missed appointments without 24 hour notice. Payment must be rendered prior to next scheduled visit.**

_____ _____

Patient Signature (18 years or older) Today's Date

FYZICAL
Therapy & Balance Centers

_____ _____

Parent/Guardian/Legal Representative for minor Today's Date