Bodies in Balance Physical Therapy

RELEASE OF INFORMATION & FINANCIAL RESPONSIBILITY:

I hereby acknowledge my responsibility for full payment of this debt for service of physical therapy and waive my rights of defense under the statute of limitations. **If utilizing insurance benefits** being made to Bodies in Balance Physical Therapy, I understand that my signature authorizes release of medical information necessary for payment of a claim to Bodies in Balance. **I understand that I am responsible for any co-payment, coinsurance deductibles** and non-covered service. I understand that filing insurance benefits is a courtesy that Bodies in Balance offers. **I further understand that while at Bodies in Balance will make best efforts in verifying insurance benefits, Bodies in Balance will not be held liable for benefit information**. I acknowledge that the **best source of my insurance benefit information is my benefit package and through contacting my insurance myself.**

In the case of **motor vehicle accidents**, I understand it is my responsibility to pay for services if the claim is denied. I will sign a provider lien in agreement of settlement. In the case of legal settlements, pending or otherwise regarding this injury I agree to make full payment for this debt regardless of the settlement decision.

INITIAL HERE:_____

REGARDING MISSED OR CANCELLED APPOINTMENTS:

One of the benefits in coming to a non-volume oriented clinic is receiving individualized care for up to one hour and expert skills provide by knowledgeable, licensed, and experienced staff. In order for Bodies in Balance PT to continue to provide these services**, we request your consideration to our staff and our patients (who may be on a waiting list) by giving us ample notice of any cancellation.** Please know that missing appointments may hinder progress toward your therapy goals and thus may require holding on therapy services until there is a better time for consistent attendance. **Please call a minimum of 24 hours before you scheduled appointment if you wish to cancel or reschedule. A NO SHOW fee of $30 will be charged if patient fails to notify clinic of pending cancellation.**

INITIAL HERE:_____

ACKNOWLEDGEMENT OF HIPAA REQUIREMENTS:

I have read and fully understand Bodies in Balance Notice of Information Practices. I understand **HIPAA** requirements and that Bodies in Balance may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation for the quality of services provided & any administrative operations related to treatment or payment. **I understand that I have the right to restrict how my personal health information is used** & disclosed for treatment, payment & administrative operation if I notify the practice. I herby acknowledge to the use and disclosure of my personal health information for the purposes as noted in Bodies in Balance Physical Therapy's Notice of Information practices, I understand and retain the right to revoke this acknowledgement by notifying the practice in a writing at any time.

INITIAL HERE:_____

DESIGNATED INDIVIDUALS AUTHORIZATION:

I herby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment. I understand that the identity of these designated parties must be verified

ReferringPhysician:_____

Other preferred Physician:_____

Other (i.e.: spouse, family member):_____

May a phone call reminder / schedule reminder or change on home phone: ☐ yes ☐ no

CONSENT TO TREAT & INFORMATION ACKNOWLEDGEMENT:

I, the undersigned do hereby agree and give my consent for Bodies in Balance Physical Therapy to furnish medical care & treatment to _____ (Patient's Name), considered necessary and proper in diagnosing or treating his / her physical condition.

_____	_____	_____
Print Name	Signature	Date