PHYSICAL THERAPY BY PHOENIX

Name of Patient: _____

Consent Form

Consent for Treatment: I consent to receive, and authorize my physical therapist and other healthcare providers and assistants involved in the care I receive from Physical Therapy By Phoenix ("Phoenix") to provide, care and treatment they deem appropriate for my condition. I acknowledge that no guarantees have been made to me by Phoenix or anyone else about results from treatment I will receive from Phoenix, and I will not hold Phoenix or its therapists or other staff liable for these results. I understand that a physical therapy diagnosis is not a medical diagnosis and that I should consult with my physician concerning any diagnoses or treatments I need that are not physical therapy services.

Assignment of Benefits & Financial Responsibility: I assign to Phoenix claims for reimbursement for services rendered under my insurance policy, health benefit plan or any settlement or judgment arising out of or related to any incident giving rise to the need for such services. I am financially responsible for my bill, including charges not covered by my insurance policy, health benefit plan or other payor, such as co-insurance, co-pay, and the deductible. It is my responsibility to familiarize myself with my plan and insurance policy.

If information regarding my insurance or payor benefits is given by Phoenix as a courtesy, it is not a guarantee of coverage or of benefits. Any estimated charges given by Phoenix may change on the final bill. Co-insurance and deductibles provided by Phoenix are estimates. If a credit card is used, I authorize Phoenix to charge and save my credit card information on file for the agreed-upon amount.

Authorization to Release or Obtain Information: I authorize release of all information needed to my insurance company, physician, or other parties for the purposes of treatment, payment and/or healthcare operations related to my safety or care. I authorize the clinic staff to contact other healthcare professionals regarding my condition and treatment.

I acknowledge that I have received a copy of the Notice of Privacy Practices from Phoenix and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

Release of Information to Others: In accordance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding scheduled appointments, the treatment I receive and the billing of my account:

_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship

Patient/Parent or Legal Guardian Signature _____

Patient Name (printed):_____

Date:_____

I authorize messages or appointment reminders in all of the following ways while protecting my medical details (check all that apply):

- ○ Text
- ○ Do not send me appointment reminders