CONSENT FOR TREATMENT: I understand I have the right to choose my physical therapy provider and have chosen *Starace Total Balance Physical Therapy P.A.* and hereby authorize and give my consent for physical therapy care deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Initial ___

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize and give my consent for

Advance Therapy to treat_____(minor's name). **Initial ____**

PRIVACY NOTICE and RELEASE OF MEDICAL INFORMATION: A Notice of Privacy Practices (NPP) is available for your review or you may take it with you. The NPP describes our comprehensive efforts to protect the privacy of your personal health and financial information. The NPP also describes how much information may be used, released or shared under the Health Insurance Portability and Accountability Act (HIPAA). **Initial____**

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION

I hear-by authorize *Starace Total Balance Physical Therapy P.A.* to share any and all of my medical / billing information with the following people:

Full Name:_____Relationship: _____

Full Name:_____Relationship: _____

FINANCIAL POLICY: As a courtesy, we will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible, and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours – you will be billed for any balance not paid by your insurance. **Initial____**

ATTENDANCE, CANCELLATION, and NO SHOW: Attendance at your therapy visits is your most important responsibility because it can make the difference between whether you succeed in your treatment or not. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require at least a 24 hour notice of cancellation so that we can put another patient in your time slot. The fee for a late cancellation or missed appointment is $25, which is the patient's responsibility. Documentation of missed appointments may be forwarded to your physician or case manager, which may jeopardize your claim. We reserve the right to discontinue treatment for non-compliance with your physical therapy program. **Initial ____**

I certify that any and all information provided by me in furtherance of my application for health care benefits are true. It has been fully explained to me and all of my questions about the form have been answered. I understand its contents.

Patient Signature:_____**Date:**_____**/**____**/**____

Staff Witness Initials: _____

STARACE TOTAL BALANCE
PHYSICAL THERAPY P.A.