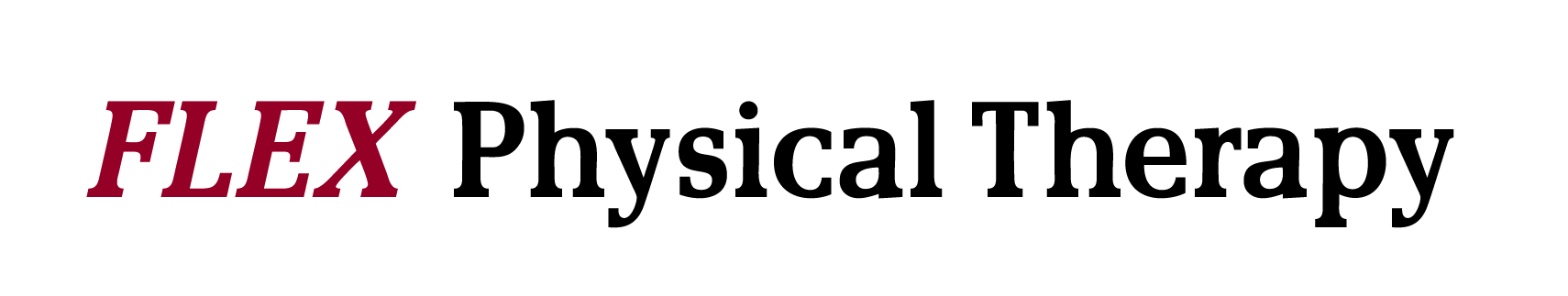
******

***#480-694-5013***

***www.flexpt1.com***

**CONSENT FOR CARE AND TREATMENT**

I, the undersigned, agree and give my consent to ***FLEX* Physical Therapy** to provide medical care and treatment to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical condition.

*Patient’s printed name*

**Patient/Guardian/Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIVACY PRACTICES**

By initialing here, I acknowledge that I have received a copy of the ***FLEX* Physical Therapy’s** Notice of Privacy

Practices and have been provided an opportunity to review it. **\_\_\_\_\_\_\_\_\_\_\_\_**

***Initials***

**FINANCIAL RESPONSIBILITY FOR PATIENTS PAYING WITH INSURANCE**

A copay/coinsurance/deductible may be required each session. Please check with your insurance as to what your copay/coinsurance/deductible may be. We can estimate the amount for you which may change when your insurance billing is processed.

The following is the **estimate** to what your copay/coinsurance/deductible may be:

Copay: $\_\_\_\_\_\_\_\_\_\_\_

Coinsurance: $\_\_\_\_\_\_\_\_\_\_\_

Deductible: $\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL RESPONSIBILITY FOR SELF-PAY PATIENTS**

If you have elected to pay for your treatment at ***FLEX* Physical Therapy** out of your own pocket. Payment is due to ***FLEX* Physical Therapy** at the time of service. In the event that a check is returned for Non-Sufficient Funds, a $25 service fee will be charged to you.

The following are the fee for services that you are responsible for:

Initial Evaluation with treatment: $150.00

Each session following Evaluation: $100.00

Please verify that you understand your financial responsibility by signing and dating this form:

*I understand and agree that if I fail to make any of the payments, I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.*

**Patient/Guardian/Responsible Party Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_**

**Clinic Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_**