GAMBRILL'S
PHYSICAL THERAPY

PATIENT NAME_____

Consent for Treatment

I do hereby agree and give my consent for Gambrill's Physical Therapy, LLC to provide medical care and physical therapy services considered necessary and appropriate in evaluation and treating my physical condition.

_____ _____
Signature Date

Assignment of Benefits/Financial Policy

It is our policy to bill your insurance carrier as a courtesy to you. I authorize payment directly to Gambrill's Physical Therapy, LLC of health insurance benefits otherwise directly to me, but not to exceed the balance due of the physical therapy services provided to me. As a patient or guarantor, I am responsible for any charges billed for services provided to me and are not reimbursed by my insurance carrier. This may include non-covered services/supplies, deductibles, co-pays or balances stipulated by my insurance plan. I will be responsible for any attorney/collection fees incurred by the facility in an attempt to collect a delinquent balance due. I will be responsible for informing Gambrill's Physical Therapy, LLC of any insurance/payor information changes while services are being rendered.

_____ Copay/Coinsurance for each visit _____Deductible Remaining

_____ _____
Signature Date

Release of Information

I understand that all information concerning my care is confidential. I authorize Gambrill's Physical Therapy, LLC to release my information to health care providers, payors and individuals related to the provision of services that may have an effect on the continuation of plan of care or in the benefits payable for services rendered.

_____ _____
Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of Gambrill's Physical Therapy, LLC Notice of Privacy Practices.

_____ _____
Signature Date

Appointment Policy

Gambrill's Physical Therapy, LLC requires a 24 hour notification if you are unable to make your appointment. Failure to comply with this policy will result in a $25 no show/no cancellation charge.

_____ _____
Signature Date

If unable to sign by patient, please indicate relationship: _____

_____ _____
Signature Date