**Authorization for Treatment**

Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do herby agree and give my consent for Whole Health Physical Therapy LLC to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. I understand the full risks and benefits and my consent is given freely and voluntarily.

RELEASE OF INFORMATION: I hereby authorize the release of any and all medical and or change information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to Insurance Payers, HMO’s Workers Compensation carriers, Medicare, Tricare, and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become part of my medical record.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Whole Health Physical Therapy LLC to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

CANCELLATION & NO SHOW POLICY: We require 24 hour notice in the event of a cancellation. The charge for cancellation without proper notice and no show is $45 for physical therapy visits. This Charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

FINANCIAL POLICY: We bill your personal insurance carrier as a courtesy to you. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for all the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for the services billed by us, you recognize the obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill. All co-pays are due prior to each physical therapy treatment.

The above information has been read and understood by me. I UNDERSTAND AND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT. I GIVE MY INFORMED CONSENT FOR WHOLE HEALTH PHYSCIAL THERAPY LLC, TO FURNISH CARE CONSIDERED NECESSARY AND PROPER IN EVALUATING AND/OR TREATMENT MY PHYSICAL CONDITION.

Patient/Patient Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_