1st Choice FYZICAL Therapy & Balance Centers

"Spelled Different Because We Are Different!"

RELEASE OF INFORMATION:

I hereby authorize 1st Choice FYZICAL Therapy and Balance Centers, Inc. to furnish information to insurance carriers concerning illness or accident and treatments, and I hereby assign 1st Choice FYZICAL Therapy and Balance Centers, Inc. all payments for medical service rendered to my dependents or me.

I authorize the release of my medical records to the agents of 1st Choice FYZICAL Therapy and Balance Centers, Inc. and/or agents so indicated by myself.

I understand that I am financially responsible for any amounts not covered by my insurance carrier, which includes amounts applied to my deductible, co-insurance, denied services, or charges deemed over "reasonable and customary".

24 HOUR APPOINTMENT CANCELLATION POLICY: Please notify us of your cancellation within 24 hours of your appointment or there will be a $50 dollar service charge.

CONSENT FOR MEDICAL TREATMENT:

I have come to 1st Choice FYZICAL Therapy and Balance Centers, Inc. for medical treatment and consent to the customary examinations, tests, treatment, and procedures performed on patients in my condition. I understand that the practice of physical therapy is not an exact science and, therefore, no guarantees have been or can be made regarding the outcome of any diagnosis, treatment, test or examination performed by 1st Choice FYZICAL Therapy and Balance Centers, Inc. I understand that my condition may get better, worse, or stay the same with physical therapy.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

I _____ have received the Notice of Privacy
Print Name
Practices from 1st Choice FYZICAL Therapy and Balance Centers, Inc.

X_____
Signature

Date_____