

Consent for Treatment

I hereby authorize the physical therapist(s) at FitHab Physical Therapy to evaluate and treat me for my current condition as may deem necessary or advisable. I acknowledge that no guarantee has been or can be made regarding the likelihood of success or outcome of any therapy. I understand the purpose of the treatment, as well as the risks involved, and possible alternatives. I may ask questions regarding my care & refuse treatment(s) or discontinue therapy at any time. I agree to provide 24-hr notice if I am unable to make my appointment. If I fail to give notice I may be subject to a cancellation fee.

I consent to receive physical therapy services and understand that my participation is voluntary.

Patient Initials: _____

Payment Information

I hereby assign all medical benefits which I am entitled to FitHab Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. I do hereby authorize FitHab Physical Therapy to release all information necessary to secure the payment of said benefits.

I understand that I am responsible for any charges not covered by my insurance, including co-pays, deductibles, and services deemed non-covered or out-of-network.

I may elect to pay out-of-pocket for physical therapy services. For patients without insurance or for those who elect to pay themselves, a discounted "cash rate" of 10% off will apply for payments made in full on day of service. A superbill may be made available upon request for self-submittal to insurance carriers.

Patient Initials: _____

Acknowledgment of Privacy Practices

I acknowledge that I have received and reviewed the Notice of Privacy Practices provided by FitHab Physical Therapy. This notice describes how my medical information may be used and disclosed, and how I can access this information.

Patient Name: _____

Patient Signature: _____

Date: _____