

PATIENT NAME

I agree to be responsible for any portion of my bill not covered by insurance. I understand and accept the responsibility of checking on my insurance benefits and complying with those requirements.

Advantage Physical Therapy reserves the right to charge \$25.00 for missed appointments or appointments cancelled without a 24 hour notice. Advantage Physical Therapy also reserves the right to discharge any patient, for any reason, including canceling and not showing for appointments. If my account has an outstanding balance over 30 days, I will be charged 1.5% per month finance charge. Insurance companies will not cover these additional charges.

I hereby consent to have treatment of physical therapy, which was prescribed by my physician. I authorize my insurance company to pay directly to Advantage Physical Therapy. I authorize the release of medical records to either my attorney or insurance company upon written request. I have completed the patient information truthfully, and have read and understand the above statements.

Proper venue for enforcement of this agreement shall lie in Spokane County, State of Washington. The courts shall have jurisdiction over the parties and subject matter of this agreement.

The undersigned acknowledges that our Notice of Privacy Practices has been made available.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

DATE

How did you hear about us?

Doctor Phone book TV Friend Website