CONSENT TO TREATMENT
AUTHORIZATION TO RELEASE INFORMATION
FINANCIAL RESPONSIBILITY

PATIENT NAME:______________________________

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance company for you, as a courtesy. You will be financially responsible for the balance of your account.

Initial:

_____I consent to **evaluation and treatment** by Physical Therapy Associates of San Ramon and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____I authorize the **release of information** acquired in the course of my treatment, including, but not limited to medical records, electronic media, oral communications to my insurance company, physicians and/ or other third party payers.

_____I authorize **phone messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers that I have provided.

_____I agree to follow the Physical Therapy Associates' **Cancellation Policy** or pay a $40.00 fee which cannot be billed to my insurance company.

_____I authorize and **assign direct payment** to Physical Therapy Associates of San Ramon for services rendered, by an insurance company and/ or attorney out of the proceeds of any settlement case.

_____I agree to pay **co-payments, deductibles, and any portions** that my insurance company will not pay. I will **pay at the time of service** if I do not have insurance coverage.

_____I agree to pay a **rebilling fee** of $10.00 per day of service; fee to be charged at the discretion of our billing department.

_____A copy of **HIPAA Notice of Privacy Practices** has been provided to me.

Patient signature______________________________**Date**_______________