In case of an emergency, please provide us with the name, relationship and phone numbers of someone we can contact.

Name: _____ Relationship: _____

Home Phone Number: ( ) _____ Work Phone Number: _____

PLEASE READ AND SIGN THE FOLLOWING POLICIES

AUTHORIZATION

I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to Optimum Performance Physical therapy. I also understand that I am financially responsible for any and all charges incurred for services rendered to me. I agree to accept full responsibility for payment should my insurance company deny payment for any reason, other than the denial for late submission. In addition, I agree to accept full responsibility for payment to include the balance remaining after the payment of possible insurance benefits.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

MEDICARE RECIPIENTS

I authorized any holder of medical or other insurance information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries, carriers or to the billing agent of these physicians, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits directly to Optimum Performance Physical therapy.

I understand that my plan of care (POC) submitted by my therapist needs to be signed in order for my benefits to be fully covered here. I accept responsibility in obtaining a signature from my doctor so I will not be held accountable for the entire cost of my physical therapy services here.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

CANCELATION POLICY

We at Optimum Performance Physical Therapy understand that there will be times when you may have to cancel your appointment at the last minute, or may miss it altogether, however we would appreciate it if you could provide us with at least 24 hours notice, as we do not overbook appointments. Your appointment is dedicated to you ONLY; therefore, we must impose a $35. cancellation fee for any more than one cancelled visit within one week. A $50 "no show" fee will be incurred for any appointment you miss that you have not cancelled. Please note that YOU, not your insurance company will be responsible for these fees.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

RETURNED CHECK POLICY

I understand that if a check I have remitted for payment of any kind is returned for any reason, I will be responsible for the amount of the check as well as a $20 returned check fee and that payment of this fee is expected within five business days from the day I am notified. I also understand that if more than one check a month is returned, I will be asked to pay for services in cash at the time they are rendered.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE