



## Balance Physical Therapy, LLC Consent Form

Please read carefully before you sign. By your signature, you acknowledge understanding of all items set forth herein. If you have questions regarding any sections, please feel free to ask.

### Consent to Medical and Therapeutic Services

I consent to the procedures, which may be performed during the duration of this outpatient treatment, including emergency treatment. I understand that if I fail to carry out the follow-up medical care, I do so at my own risk.

I understand that those individuals who attend patients at this facility may include medical, Physical Therapy and other healthcare personnel in training who, unless requested otherwise, may be present during patient care or may provide care as part of their education.

I also understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation all together.

### Financial Agreement/Guarantee of Payment and Assignment of Benefits

**For Medicare Beneficiaries:** I request that payment of authorized Medicare benefits be made on my behalf to Balance Physical Therapy, LLC. I authorize Balance Physical Therapy, LLC, if it chooses, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. Balance Physical Therapy, LLC, its agents and employees are hereby released from any and all liability of any nature that may arise from the release of information.

I understand that all insurance coverage estimates quoted to me and/or other responsible party is estimated, and that I and/or other responsible party shall be liable for all charges not covered by Medicare whether or not such coverage agrees with the amount estimated. I certify that I have disclosed any and all health insurance coverage information. I understand that I am financially responsible for all charges whether or not paid by Medicare.

**For all other patients:** I understand that payment is due at the time of treatment via cash, check, MC, Visa or American Express. I understand that it is my responsibility to call my insurance company to estimate my reimbursement and completely understand my Physical Therapy benefits. Additionally, I understand that it is my responsibility to assist Balance Physical Therapy, LLC staff in obtaining any required referrals when necessary. Furthermore, I understand that it is my responsibility to send the paperwork provided by Balance Physical Therapy, LLC to my insurance carrier for their consideration of reimbursement to me. I understand that Balance Physical Therapy, LLC will provide me with any documentation requested by me and/or my insurance carrier. Lastly, I understand that the amount of reimbursement I will receive will vary according to the terms of my insurance policy. Balance Physical Therapy, LLC will not make guarantees or estimates regarding what reimbursement my plan allows and I am ultimately responsible for payment for the services provided by Balance Physical Therapy, LLC.

### Notice of Privacy Practices

I acknowledge that I have received the Balance Physical Therapy, LLC Notice of Privacy Practices.

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Patient/Legal Guardian Signature

Date

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Patient Address

Telephone Number