FYZICAL
Therapy & Balance Centers

9735 Southwest Highway
Oak Lawn, IL 60453
708-499-4497
www.fyzical.com/oaklawn

Consent Form

_____ **Consent for Treatment:**
(Initial) I hereby consent to receive care for therapy services by Fyzical Therapy & Balance Centers™. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

_____ **Consent to Release Medical Information:**
(Initial) I authorize Fyzical Therapy & Balance Centers™ to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____.
(Spouse/ relative/ guardian/ other)

_____ **Consent to Obtain Medical Information:**
(Initial) I authorize Fyzical Therapy & Balance Centers™ to obtain and acquire any information that would be beneficial in connection with my therapy services, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

_____ **Assignment of Insurance Benefits:**
(Initial) I hereby authorize payment to be made directly to Fyzical Therapy & Balance Centers™.

_____ **Guarantee of Payment:**
(Initial) I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

_____ **Cancellation/No Show Policy:**
(Initial) As a provider of excellent care to you and all clients, it is very important that appointments are kept in order to comply with physician orders for an effective recovery. It is the responsibility of each patient to attend each scheduled appointment. If an unexpected event occurs notification is expected prior to the scheduled appointment.
There will be a $25.00 fee for not canceling scheduled appointments without notification.

_____ **Medicare Cap:**
(Initial) By signing below, I agree that I have read and understand the information given to me regarding the Medicare Cap beginning on January 1st, 2018. I understand that it is my responsibility to inform Fyzical Therapy & Balance Centers™ of any other therapy services performed on or after January 1st, 2018. I also understand that I am financially responsible for any charges not paid by Medicare and/or my secondary insurance.

I hereby certify that I understand these rights as set forth.

Patient Signature:_____ **Date:** ____/____/____