

**MEDICAL INFORMATION RELEASE**

I hereby authorize THRIVE PHYSICAL THERAPY to release or request any information acquired or needed in the course of my examination or treatment to or from my insurance provider, attorneys, and/or physicians. A photocopy of this authorization shall be considered as effective and valid as the original.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONSENT FOR TREATMENT**

I consent to have THRIVE PHYSICAL THERAPY provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time. Signature of parent/guardian is required for patients 17 years and younger.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS TO THRIVE PHYSICAL THERAPY**

I understand that my signature requests that assigned medical benefits be paid directly to THRIVE PHYSICAL THERAPY/Curtis Cookingham, MHS, P.T. I understand that I am financially responsible for the charges not covered by this assignment and that excess payment will be refunded.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PATIENT RESPONSIBILITY**

I have read the billing policy and assume full responsibility for all expenses incurred in treatment. In the event that legal action should become necessary to enforce payment of any charges, I agree to be responsible for and pay all reasonable attorney fees and costs incurred. There may be procedures or supplies that my therapist will provide that s/he feels is medically necessary but my insurance may not cover or determine “reasonable and necessary”. By accepting these procedures (i.e., phonophoresis, iontophoresis) and/or supplies (e.g. Dexamethasone, electrical stimulation pads, theraband), I agree to be fully responsible for payment. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL UNPAID BALANCE OF MY BILL.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Note: ESTIMATED coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. It is the patient’s responsibility to know what your insurance will cover. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company.