



**CONSENT FOR TREATMENT**

I, the undersigned, a patient of Peak Physical Therapy & Wellness Center, pllc hereby authorize Peak Physical Therapy and Wellness Center, pllc and whomever may be designated as the Physical Therapist of record and his/her assistant(s) to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE**

I hereby authorize the Insurance Company / Insurance Administrator to make payment directly to Peak Physical Therapy & Wellness Center, pllc for the benefits allowable and otherwise payable to me, under my current insurance policy as payment toward the total charges for professional services rendered. I agree to pay, in a current manner, any balance of said professional charges. I agree that Peak Physical Therapy & Wellness Center, pllc be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Peak Physical Therapy & Wellness Center, pllc will prepare any necessary reports and forms to assist me in making collection from the insurance company.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**APPOINTMENT CANCELATION POLICY**

I understand that a 24 hour notice must be given when canceling or rescheduling an appointment. I also understand that if a 24 hour notice is not given, I will be responsible for paying a **\$40 no show fee**.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**RETURNED OR NSF PAYMENTS**

I understand that I will be responsible for promptly paying for any balance due to Peak Physical Therapy & Wellness Center, pllc that is accrued due to the return or NSF of any payment that I make to Peak Physical Therapy & Wellness Center, pllc. In addition, I understand that I will also be responsible for paying a **\$20 fee** for each item that is returned by my bank.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR TREATMENT OF A MINOR**

I hereby authorize Peak Physical Therapy & Wellness Center, pllc and whomever may be designated as the Physical Therapist of record and his/her assistant(s) to administer care as he/she deems necessary to (please indicate relationship to child and child's name)

---

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE**

I, the undersigned patient, direct my Attorney to pay any outstanding bills out my settlement, and in effect, protect any such balance. I fully understand that I am directly responsible for all medical bills, and this agreement is made solely for the physical therapist's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said balance. I have been advised that if my attorney does not wish to cooperate in protecting the physical therapist's interest, the physical therapist will not await payment, but will require me to make payment on a current basis.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I, the undersigned, a patient of Peak Physical Therapy & Wellness Center, pllc have read and understand the stated policies.

Patient Signature \_\_\_\_\_ | \_\_\_\_\_ Date \_\_\_\_\_