In Balance Physical Therapy

Marci Cody MPT
OL #2843

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Patient Information

Last Name	First Name	Middle Initial
Birth Date	**Sex**	**Current Date**

Address	Street/Apt. #	City	State	Zip

Home Phone	Work Phone	Cell Phone

Email

Consent to Treat:
Consent/release of information: I, _____, consent to all physical therapy treatments including, but not limited to evaluation, manual therapy techniques, and exercise instruction.
My Doctor's name is _____, and I authorize Marci Cody, M.P.T. to release information to him/her.

Financial Agreement:
I require payment at the time of service. The patient is responsible for the account. My fees are $190 for the primary visit, which includes an evaluation, diagnosis, and treatment; and $175 per standard treatment visit thereafter.

Cancellations:
There will be a $90 fee for all cancellations made less than 24 business hours before a scheduled appointment. Every effort will be made to fill the appointment, if we are able to fill it no fee will be charged.

Agreement:
I understand and agree with the aforementioned consent, financial agreement, and cancellation fee details.

Patient Signature _____ **Date**_____

Insurance and Insurance Pre-authorizations:
While we are a "Cash Pay" clinic and full payment is due at the time of services, our office will prepare a receipt for you to submit to your insurance company for reimbursement.
I understand that some insurance companies require prior authorization requirements be met to receive benefits, and that it is my responsibility to verify my insurance benefits for physical therapy. Initial:_____Date:_____

Authorization: I authorize the release of any medical or other information necessary to process my claim:

Signature:_____**Date:**_____