**Phoenix Physical Therapy**



**Consent Form**

**10121 W Clearwater Ave Suite 113, Kennewick, WA, 99336**

**Phone: 509-491-3807 Fax: 509-593-5020**

Patient Name:

* **Consent for Evaluation and Treatment**

I hereby agree and give consent for myself, or as parent/guardian for my minor child, for Phoenix Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in assessing and treating my physical condition.

* **Consent to Release Medical Information**

I authorize Phoenix Physical Therapy to release any information, verbal and written, acquired in connection with my therapy services including, but not limited to, diagnosis, medical records, and other related information, to myself, my insurance company, case manager, attorney, related healthcare provider, assignees and/or beneficiaries as it relates to my treatment or payment for services provided.

* **Consent to Obtain Medical Information**

I authorize Phoenix Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

* **Acceptance of Cancellation Policy**

I agree to notify Phoenix Physical Therapy 24 hours prior to my appointment should I need to cancel or reschedule. I also understand if my therapy is covered by a worker’s compensation carrier, Phoenix Physical Therapy is required to notify my case manager if I cancel an appointment and do not reschedule, or if I fail to keep a scheduled appointment.

* **Assignment of Insurance Benefits**

I authorize and assign direct payment to Phoenix Physical Therapy of any sum now or hereafter owed. I give assignment and lien against any claims against a third party whose negligence may have caused me injury, up to the amount of the bill for treatment.

* **Guarantee of Payment**

I understand that I am responsible for all fees incurred here at Phoenix Physical Therapy that are not covered by my insurance plan. I agree to pay any unpaid balances for services rendered. I understand that if I fail to make any of the payments in a timely manner, my account will be assigned to a licensed collection agency or attorney, and a collection fee of up to forty percent (40%) of the debt assigned will be added to the amount owed pursuant to the terms hereof and as allowed by law.

* **Acknowledge Receipt of Privacy Practices**

I acknowledge I have reviewed the Privacy Practices for Phoenix Physical Therapy. A copy of this notice is available upon my request.