plan physical therapy
injury . recovery . connected

Authorizations and Agreements

Patient First Name (please print) _____ Patient Last Name (please print) _____

Name of Responsible Party (if patient is under age 18) _____

Authorization to Provide Treatment
I authorize Plan Physical Therapy, Inc. (PPT) to provide me with physical therapy care and medical treatment considered necessary and proper in the diagnosing and treating my physical condition through their services, programs, therapy, and any other means appropriate for delivering this service.

_____
Signature

Burden to Furnish Health Information Pertinent to Care Being Received
I understand that if my medical status or history changes, that I am wholly responsible for notifying PPT with written record before any further therapy services are rendered to ensure my safety and the effectiveness of the program.

_____
Signature

Authorization for release of Medical Information
I hereby authorize PPT to procure/provide any and all medical information that may be determined useful, necessary, and proper to provide therapy services or treatment.

_____
Signature

Financial Responsibility Policy Acknowledgement
PPT will bill your insurance company for you to help maximize the benefits of your policy in restoring your health. I understand that it is ultimately my responsibility to monitor insurance benefits and know what services are covered and at what amount. Accordingly, I understand that any unpaid amount is my responsibility.

_____
Signature

Cancellations
Cancellations are accepted if provided during business hours **and** 24 hours before your scheduled appointment. After your second "late cancelled" or "no-show" appointment, you will be billed at a rate of $35/occurrence due to the loss of time and resources that would have been used for other patients. Thank you for your attention to this important policy.

HIPAA Privacy Practice Acknowledgement
I have read and understand PPT's Notice of Private Information Practices and my rights associated. I have listed the names below that I would like to grant access to me medical information with PPT.

_____
Signature

_____ _____

By signing below, I indicate that I thoroughly understand and agree to all the aforementioned. Further, I understanding these terms, I give my informed consent to provide me with services and/or treatment.

_____
Signature

8525 N. Cedar Avenue, Suite #109
Fresno, CA 93720
www.planphysicaltherapy.com
p: 559.440.9200
f: 559.440.9222