6650 W. 44th Ave Wheat Ridge, CO 80033 ·303-993-9767 ·holisticpt.net

Please initial by each line indicating that you have read and agreed to statement:

Consent to Treat:

_____ I agree and give my consent to Holistic Physical Therapy, PC to provide physical therapy and treatment considered necessary and appropriate in diagnosing and/or treating your condition.

Assignment of Benefits:

_____ I hereby assign payments for services rendered directly to Holistic Physical Therapy, PC and authorize release of information necessary to process my insurance claims. I agree to pay all co-payments and co-insurance amounts required, deductibles and any portion that my insurance company will not pay.

_____I understand that co-payments and co-insurance amounts are to be me at the time of service.

_____ I understand that if this is a motor vehicle accident and the medical benefits are exhausted, the financial responsibility reverts to my health insurance. If this account goes to collection, I will be responsible for fees incurred. A $30 fee will be added for any returned checks.

_____**Holistic PT will bill your insurance company if requested to do so. We will do our best to collect the correct amount at time of appointment but you are responsible for any additional payments not covered by your insurance.**

Cancellation/No Show Policy:

_____ I must cancel my appointment > 24 hours prior to my next appointment, or I will be charged a **$70 cancellation fee**. This cancellation fee is not covered or billed to my insurance company but it is my sole responsibility to pay. If I am > 15 minutes late for my appointment, I will be charged the **cancellation fee** and will have to re-schedule for another time.

Release of Information:

_____ I authorize the release of any of my medical records, reports or imaging to Holistic Physical Therapy, PC for obtaining medical information relevant to my treatment. I authorize Holistic PT to send copies of documents related to my treatment to my primary care physician and/or referring physician.

Acknowledgement of Receipt of Notice of HIPAA

_____ I acknowledge that I have read the Notice of Privacy Acts from Holistic Physical Therapy, PC and understand it completely.

By signing below, I acknowledge that I have ready, full understand and agree to all the statements and policies at Holistic Physical Therapy, PC.

Signature: _____

Date: _____