

Intending to be legally bound, I hereby agree as follows:

Appointment Cancellation / No show Policy: I hereby acknowledge that all appointments with All Forms Physical Therapy have been made at the direction of my Physician and that I am responsible for a service fee of \$25.00 for each appointment canceled with less than 24-hour notice. A \$35 fee may be charged for repeated cancellations without 24-hour notice.

Initials: _____

Representation that insurance premiums have been paid: I hereby warrant all insurance policies under which payment to All Forms Physical Therapy may be made are current and will be kept current during my treatment.

Initials: _____

Acknowledgment of Liability: I understand and agree that my obligation to pay All Forms Physical Therapy is not contingent on payment of any insurance, settlement, judgment, verdict, award or any other payment to which I am now, or may be, entitled and that I am personally responsible for the full amount of all services rendered by All Forms Physical Therapy.

Initials: _____

Authorization to assign medical benefits and make direct payments to All Forms Physical Therapy: I hereby authorize and direct my attorney and all insurance carriers which are, or may be obligated to make payment of any benefits to me or on my behalf to make direct payment to All Forms Physical Therapy of all invoices from All Forms Physical Therapy. I further direct my attorney and all such insurance carriers to pay All Forms Physical Therapy first from any funds due to me and to reserve as a first priority funds from any insurance proceeds, settlement, judgment, verdict, award or any other payment due to me or received on my behalf in order to discharge my obligations to All Forms Physical Therapy in full.

Initials: _____

All Forms Physical Therapy Reliance: I understand that All Forms Physical Therapy agrees to provide Physical Therapy services without demanding immediate payment in full, in express reliance upon this agreement, your representations and your warranty that there is insurance, or other funds, available, or your agreement to pay All Forms Physical Therapy directly. The provision of therapy services without demanding immediate payment in full shall be sufficient consideration for this agreement. This agreement is not intended to replace or in any way change your responsibility for the payment of your bills. Notwithstanding the foregoing, I agree that All Forms Physical Therapy may demand payment in full from me at any time hereafter.

Initials: _____

No revocation or amendment: I hereby agree that the promises, representations, warranties and authorizations made herein shall not be revoked or amended without the written consent of All Forms Physical Therapy.

Initials: _____

Patient: _____ Signature _____ Date: _____

Age: _____ Date of Birth: _____

Parent / Guardian: _____ Signature _____