

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Finishline Physical Therapy's Notice of Information Practices. I understand that Finishline Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Finishline Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Finishline Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

Cancellation Policy: You must arrive 10 minutes prior to you scheduled appointment to prepare for treatment. We request that you please give at least 24 hours notice if a cancellation is necessary to avoid a \$50.00 late cancellation charge. In order for us to verify your appointment, please make sure to bring you schedule card to the appointment.

Financial Agreement: I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed directly to:

Finishline Physical Therapy
531 N. Larchmont Blvd.
Los Angeles, California
90004-3013

If current policy prohibits direct payment to Finishline Physical Therapy, then I hereby also instruct and direct you to make out the check to me, the patient, as follows:

_____ (Patient's Name)

Finishline Physical Therapy
531 N. Larchmont Blvd.
Los Angeles, California
90004-3013

The professional or medical expense benefits allowable and otherwise payable to me under the current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient

Date of Signing