CONSENT FORM/RELEASE OF INFORMATION

Patient Name _____

CONSENT TO EVALUATION AND TREATMENT
I do hereby consent to the evaluation and treatment by Horizon Physical Therapy & Rehabilitation. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION
I authorize Horizon Physical Therapy & Rehabilitation to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to my physical therapist, and the Insurance Company for communication and care coordination on my behalf. I acknowledge that the contents of the information disclosed may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis. I consent to Horizon Physical Therapy & Rehabilitation leaving confidential messages including appointment reminders and or other health care information on my answering machine or voicemail for the home and or mobile phone numbers provided.

PRIVACY PRACTICES
I acknowledge receipt of the Horizon Physical Therapy & Rehabilitation Notice of Privacy Practice, which I have received at the time of this admission or previously.

ASSIGNMENT OF BENEFITS
I request that payment of the Medicare/Other Insurance benefits be made on my behalf to Horizon Physical Therapy & Rehabilitation for any services furnished to me by Horizon Physical Therapy & Rehabilitation. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL AGREEMENT
The undersigned agrees, whether signing as an agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Horizon Physical Therapy & Rehabilitation. Horizon Physical Therapy & Rehabilitation will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

CANCELLATION POLICY
The undersigned is aware and agrees, whether signing as an agent or patient, to Horizon Physical Therapy & Rehabilitation's 24 hour notice for cancelled appointments. If you cannot keep your appointments because of and emergency or illness we understand**. Failure to notify us will result in a $25 "No Show Fee".** Excessive cancellation or no-shows may result in patient discharge from physical therapy services.

Medicare Patients: I understand that if I do not have supplemental insurances, I will be responsible for the co-insurance portion not paid by Medicare as well as any deductible.

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness Date