Patient Name: _____

Please initial each line and sign below:

___ I consent to physical therapy services at BE Fit Physical Therapy. If I have any questions about my care, I should ask my physical therapist about them. It is up to me to inform the physical therapist/staff about my medications and any health concerns, allergies, or questions I have regarding my care. I understand that I need to keep my physical therapist informed about any changes that occur in my health status and medications.

___ I agree to pay for services provided by BE Fit Physical Therapy. The fees for our services are based on reasonable and customary charges in this area, and will be billed to the insurance that you provide. It is my responsibility to provide accurate insurance information at the start of care, and to immediately update these insurance records with any changes. If you do not have insurance, BE Fit offers self-pay options, and requires that all charges are paid at the time of service.

___ I will be responsible for charges not covered by my insurance company including but not limited to deductibles and co-pays. I am also responsible for payment of any late cancellation charges, supplies and additional services not covered by my insurance.

___ **BE Fit's Cancellation Policy is a minimum 24 Hours Notice**. By canceling or rescheduling any appointment with less than 24 hours notice, or by not coming to a scheduled appointment, I will be subject to a **$50.00 cancellation or no-show fee**.

___ I agree to pay all statements in a timely fashion upon receipt. If I am having trouble paying my balance, then BE Fit can help to break the payments down into a payment plan of smaller increments.

My signature below indicates that I agree to all of the above initialed statements, and have been offered a copy of BE Fit's HIPAA Notice of Privacy Practices, which we abide by to ensure the confidentiality of your medical records.

_____ _____

Patient/Responsible Party Signature **Date**

Progress notes will be sent to the physician offices you have provided to us, and will only be released to your insurance company if they require it for billing. If you would like to permit any other individual(s) to have access to your medical record or financial record, please list their full names and their relation to you below:

Full Name	Relation (doctor, trainer, etc)

___ I give BE Fit Physical Therapy permission to leave a message on my voicemail/answering machine.