Balance and Neuro Physical Therapy
4141 SW Frwy Ste #100
Houston, Tx 77027
Ph# (713) 223-1800
Fax# (713) 223-1801
Houston's Total Balance Solution

Date: _____

Patient Name: _____
Date of Birth: _____

Consent for Medical Treatment and Release of Information

1._____ Consent for Health Care Services: I authorize consent for medical treatment at Balance and Neuro Physical Therapy.

2._____ Authorization for Release of Information: Balance and Neuro Physical Therapy may release information from my medical records to any health care provider involved in my care and treatment. Balance and Neuro Physical Therapy may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Balance and Neuro Physical Therapy is no longer responsible for the confidentiality of any information known or possessed by the payer.

3._____ Financial Agreement: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Balance and Neuro Physical Therapy which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Balance and Neuro Physical Therapy, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Balance and Neuro Physical Therapy. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.

4._____ Pre-authorization Requirements: I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Balance and Neuro Physical Therapy charges.

5._____ Assignment for Direct Payment: I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Balance and Neuro Physical Therapy.

6._____ Charge for No Show/Cancellation without 24 hour notice: I understand that 24 hour notice is required for canceling an appointment, and I will be charged a $50.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of Balance and Neuro Physical Therapy HIPAA Policy.**

_____ _____
Signature of Patient or Legally Responsible Person Name (Please print)

_____ _____
Relationship/Reason Why Patient Is Unable to Sign Date