Patient Name:____**Date of Birth:**_________________

Covered Benefits: As a courtesy, we attempt to verify therapy benefits with your insurance carrier; however verification is only an explanation of benefits based upon information that we received from your insurance carrier. Verification is not a guarantee of payment. You are responsible for payment of any deductible, co-payment/co-insurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you elect to continue therapy past your allowed/approved visits, payment will be expected from you. Please contact your insurance carrier directly to confirm your individual benefits for Physical/Occupational Therapy services.

I have read the above statements. It is my understanding that I am financially responsible to Panorama Physical Therapy for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to Panorama Physical Therapy. I agree to pay the full amount of all charges incurred by the named patient that are not covered by my insurance carrier.

Patient Signature: ____ **Date:**_______________

Guarantor's Signature (if patient is a minor): ____

Attendance Policy: We take your care seriously but understand that there are times when you must miss an appointment. We request 24-hour notice for cancellations. You may be accessed a $25 cancellation fee for cancellations without notice or reason. If you miss 3 or more consecutive appointments, all future appointments may be cancelled. So that we may provide individual care to each of our patients, if you arrive more than 10 minutes later than your scheduled time, you may be asked to reschedule your appointment.

Initials:______

Medical Release: I hereby authorize Panorama Physical Therapy to release my medical records to physicians, insurance companies, and other social agencies as necessary. I also authorize Panorama Physical Therapy to obtain any portion of my medical record from any other institution that is deemed medically necessary in the course of my treatments.

Initials:______

Consent to Provide Treatment: I hereby authorize Panorama Physical Therapy through its appropriate personnel to perform upon me, or the above named patient, appropriate assessment and treatment procedures.

Initials:______