



Consent For Treatment and Financial Responsibility

1. I hereby consent and authorize my physical therapist of Trainingzone and its employees to carry out diagnostic testing, medical procedure(s) and/or specific treatments as prescribed by my physician or other health care professional. No substantial procedures will be performed without my having an opportunity to discuss them to my satisfaction with the physical therapist who performs such procedures. I am also aware that the practice of physical therapy is not an exact science, and no guaranties have been made regarding the results of treatment and examinations.

2. I understand and agree that Trainingzone shall not be liable for the loss or damage of my money, jewelry, eyeglasses, dentures, hearing aids, garments, or other articles of personal property.

3. **Release of Information:** I hereby authorize Trainingzone and its healthcare professionals who render services to release any and all medical information obtained during this visit to the patient's physician and/or other healthcare professionals for the purpose of follow up care. I authorize Trainingzone and its agents to release any medical and billing information necessary (whether to determine liability for payment, to obtain payment for services provided, to determine medical necessity, or for other related purposes), to my insurance company, Medical Assistance agency, Medicare, worker's compensation program/employer and/or to any agents or representatives of the aforementioned.

4. I understand that I am financially responsible to Trainingzone for all charges not covered by my health care plan or worker's compensation. I hereby authorize payment of insurance benefits otherwise payable to me to be paid directly to Trainingzone. Such payments may not exceed the balance due for the Trainingzone regular charges for services provided to me.

5. I understand that I will be billed separately for services provided to me or on my behalf during this period of treatment by Trainingzone.

6. *For Medicare Beneficiaries only:* I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program and/or its intermediaries or carriers or to any professional review organization any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

7. I understand that Trainingzone maintains a tobacco and substance- free campus and that I cannot use tobacco products or substances of any kind during my visit.

8. I understand that photographs, videotapes, or other images may be recorded to document my care, and I consent to this. I understand that any images retained by Trainingzone that identify me will be released only upon written authorization from me, unless authorized or required by law.

I understand TrainingZone requires a 24 hour cancellation notice, and if fail to do so or do not show up for my scheduled appointment, I will be responsible for a \$35 fee.

Signature of Patient _____ Date _____
 Witness _____ Date _____

If the patient is a minor/has a legal guardian or is unable to sign, complete the following: Patient did not sign because

 Signature of Patient _____ Date _____
 Witness _____ Date _____

I acknowledge receipt of the Notice of Health Information Privacy Practices:
 Signature _____ Date _____
 Patient did not sign because _____