

Blue Sky Physical Therapy

155 S. Madison St Suite 303, Denver, Colorado, 80209 • Phone 303-388-1537 • Fax 303-388-4470

Patient Name: _____

First Name

Middle Initial

Last Name

CONSENT TO TREAT:

I agree and give my consent for Blue Sky Physical Therapy., P.C. to furnish physical therapy care and treatment considered necessary and proper in diagnosing and /or treating my physical condition.

_____ [initial here]

ASSIGNMENT OF BENEFITS:

I hereby assign payment for services rendered directly to Blue Sky Physical Therapy, P.C. and authorize release of information necessary to process my insurance claims. I agree to pay all co-payments required, deductibles and any portion that my insurance will not pay. I understand that co-payments are to be made at the time of service. I understand that if this is a motor vehicle accident and the medical benefits are exhausted then financial responsibility reverts to my health insurance. If this account goes to collection, I will be responsible for all fees incurred. A \$30.00 fee will be added for any returned checks. A \$5.00 monthly rebill charge is added to patient balances which are 30 days past due.

_____ [initial here]

CANCELLATION/NO SHOW POLICY:

Unless cancelled at least 24 hours in advance, our policy is to charge **\$30.00** for missed appointments per each half hour scheduled. We may have patients waiting for appointments on a cancellation list and your courtesy of a phone call allows us to schedule them. This cancellation charge is not covered or billed to your insurance company, but is your sole responsibility to pay. A total of **three** cancellations and/or no shows may result in discharge from our practice and/or notification of your insurance company of non-compliance. Individuals who are more than 15 minutes late will be charged a cancellation fee and be required to re-schedule their appointment for another day.

_____ [initial here]

RELEASE OF INFORMATION:

I **do/do not** (please circle one) authorize _____ (physicians name) to release any of my medical records, reports, x-rays, or diagnostic images to Blue Sky Physical Therapy, P.C. for the purpose of obtaining medical information relevant to my treatment.

_____ [initial here]

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ hereby acknowledge that I have received the Notice of Privacy Practices from Blue Sky Physical Therapy, P.C. and understand it completely.

_____ [initial here]

Signature _____ Date: _____

FOR OFFICE USE ONLY:

In lieu of patient signature, I _____, a staff member of Blue Sky Physical Therapy, P.C. state that _____ has been given our current Notice of Privacy Practices.