Patient Name:____

Consent for treatment	I do herby agree and give my consent for Horizon Physical Therapy & Rehabilitation to provide medical care and physical therapy services considered necessary and appropriate in evaluation and treating my physical condition.
Financial Policy	It is our policy to bill your insurance carrier as a courtesy to you. I authorize payment directly to Horizon Physical Therapy & Rehabilitation of health insurance benefits otherwise directly to me, but not to exceed the balance due of the physical therapy services provided to me. As a patient or guarantor, I am responsible for any charges billed for services provided to me and are not reimbursed by my insurance carrier. This may include non-covered services/supplies, deductibles, co-pays or balances stipulated by my insurance plan. I will be responsible for any attorney/collection fees incurred by the facility in an attempt to collect a delinquent balance due. I will be responsible for informing Horizon Physical Therapy & Rehabilitation of any insurance/payor information changes while services are being rendered.
Release of Information	I understand that all information concerning my care is confidential. I authorize Horizon Physical Therapy & Rehabilitation to release my information to health care providers, payors and individuals related to the provision of services that may have an effect on the continuation of plan of care or in the benefits payable for services rendered.
Receipt of Notice of Privacy Practices	I hereby acknowledge that I received a copy of Horizon Physical Therapy & Rehabilitation Notice of Privacy Practices.
Appointment Policy	Horizon Physical Therapy & Rehabilitation requires a 24 hour notification if you are unable to make your appointment and reserves the right to discharge upon 3 or more missed appointments without notice, or cancelled without 24 hour notice.

Patient Signature ____

Date:____

Authorized Representative: ____

Relationship to patient:________________________________