

PATIENT NAME

At Parkside Physical Therapy, it is our *TOP PRIORITY* to offer every client superior, one-on-one physical therapy treatment in a beautiful, healing, and health-promoting environment.

Please help us to continue offering this extraordinary level of care by *BEING PROMPT* for all appointments and by notifying us *AT LEAST 24 HOURS* in advance if you must cancel.

I agree to be responsible for any portion of my bill not covered by insurance. I understand and accept the responsibility of checking on my insurance benefits and complying with those requirements.

Parkside Physical Therapy reserves the right to charge \$25.00 for missed appointments or appointments cancelled without a 24 hour notice.

Parkside Physical Therapy also reserves the right to discharge any patient, for any reason, including canceling and not showing for appointments. If my account has an outstanding balance over 30 days, I will be charged 1.5% per month finance charge. Insurance companies will not cover these additional charges.

I hereby consent to have treatment of physical therapy, which was prescribed by my physician. I authorize my insurance company to pay directly to Parkside Physical Therapy. I authorize the release of medical records to either my attorney or insurance company upon written request. I have completed the patient information truthfully, and have read and understand the above statements.

Proper venue for enforcement of this agreement shall lie in Spokane County, State of Washington. The courts shall have jurisdiction over the parties and subject matter of this agreement.

I am aware that a copy of Parkside Physical Therapy's *Notice of Privacy Practices* is available to me upon my request.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

DATE