Advance Physical Therapy & Wellness, Inc.
13830 58th Street N; Suite 409
Clearwater, FL 33760

PATIENT INFORMATION CONSENT FORM

I acknowledge that I have **received/declined** a copy of the Notice of Our Privacy Practices from the office of Advance Physical Therapy . **Initials of Patient __**

I understand that some of my health information may be used and /or disclosed by Advance Physical Therapy to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures, I should refer to your privacy notice entitled, "Notice of Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form. I understand that over time your privacy practices may need to change in accordance with the law and that if I wish to obtain a copy of this notice as revised, I can call your office to request a copy.
I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations and that I can also revoke this consent in writing, but only to the extent that your practice has not taken action in reliance thereon.
I understand that for my protection any requests to amend my health information or to access my medical records must be made in writing.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/ TREATMENT & AGREEMENT TO PAY

I authorize payment of medical benefits to Advance Physical Therapy & Wellness, Inc., for therapy services rendered to me. This authorization is to cover continuous medical services. I understand that I am financially responsible for charges not covered by this authorization, except where prohibited by law.
Advance Physical Therapy & Wellness, Inc. will bill your insurance company for services rendered. I agree to that, should the amount paid by my insurance be insufficient to cover the entire treatment expense, I will be responsible for the payment of the difference. I understand that any unpaid balances may be turned over for collection and, should legal action be required, that I will be responsible for court costs and attorney fees.
Remember that you are receiving treatment from us. We are not treating the insurance company. It is your responsibility to see that we are reimbursed for services rendered to you.

I certify that I have read and understood the above information and I am willingly submitting myself to treatment at Advance Physical Therapy & Wellness, Inc.

Printed Name ______________________________________Date:
Patient's Signature _________________________________Date:

I permit a copy of this authorization to be used in place of the original