Momentum

Physical Therapy 160 Flynn Avenue ● Burlington, Vermont 05401 ● Phone 802 864-6262 ● Fax 802 864-6252

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of services at Momentum Physical Therapy. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services.

This consent shall be ongoing for a period not to exceed one year.

I (or _____ for _____) have read this form and fully understand and accept its terms and conditions.

_____

Patient or person authorized to consent for patient/relationship Date/Time

_____

Reason patient was unable to consent

_____

Witness signature

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to Momentum Physical Therapy and understand that I am financially responsible for non-covered services. I understand that if Momentum Physical Therapy does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize the physician and/or Momentum Physical Therapy to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge.

In addition, I understand and agree with Momentum Physical Therapy's "no-show," / cancellation / rescheduling policy: I will be charged a $25.00 fee in the event that I miss an appointment, cancel and / or reschedule in less than a 24-hour period. Personal Training clients will be charged for a full session.

_____

Signature Date

(TURN OVER)