Consent for Treatment
By signing this document, I _____ am giving Jenny Balbarin, MS, PT (AZ Lic. #6243) &/or Michael Balbarin, PT (AZ Lic. #6232) authorization to provide Physical Therapy services. I understand that I have the right to have any questions answered prior to receiving treatment, including risks and alternatives to the treatment plan.
Initial: _____

Notice of Patient Information Practices
I understand that Vitality Physical Therapy & Wellness may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Vitality Physical Therapy & Wellness will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes of treatment or payment. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
Initial: _____

Billing Policy/ Collections Policy
As a courtesy to our patients, Vitality Physical Therapy & Wellness will make attempts to contact your insurance carrier(s) to obtain plan benefits prior to your first date of service. ***Although every effort will be made to obtain the most current information, it is not a guarantee of your insurance coverage.*** While we accept most insurance, payment amounts vary based on your specific plan. We suggest that you contact your insurance carrier to determine what is covered for physical therapy services by your plan. Upon receipt of payment from your insurance company, the allowed balance will be transferred to you. **Co-payments are due at the time of service. In the unfortunate event that an account should go to collections, an additional 25% will be added to the account balance, in order to accommodate collection fees.** An itemized billing statement of the services provided to you is available at anytime at your request. Please ask your therapist or you may call 480-983-8600.
Initial: _____

Cancellation/"No Show" Policy
We ask that you call the office 24 hours in advance if you are unable to attend a scheduled appointment. This allows us to fill the appointment time with others who may be waiting for therapy.
Missed appointments that do not provide advanced notice will be subject to our "No Show" Policy.
(Two (2) consecutive "No Shows" for scheduled therapy appointments may subject the individual to cancellation of all future appointments).
Initial: _____

Medical Records Fee
For a complete copy of your (per case) medical records, there will be a $25-$75 processing fee. ($0.10/indiv sheet).
Initial:_____

I have read and understand the above information.

Patient/Guardian Signature: _____ Date: _____

RETURNING PATIENTS ONLY
Patient/Guardian Signature: _____ Date: _____