DONNA BEHR LLC
PHYSICAL THERAPY

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Needham, MA

MEDICALLY INFORMED CONSENT ASSIGNMENT AND RELEASE

I voluntarily consent to physical therapy treatment for the above named client 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 these services at Donna Behr Physical Therapy, LLC. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that being used to retrain, recruit and restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how she is trying to achieve them. This consent shall be ongoing for a period valid for one year from date listed below.

- I certify all the information provided is correct and true to the best of my knowledge.
- I will be responsible for payment of services at each visit, unless other definitive financial arrangements have been made prior to treatment.
- I understand that Donna Behr Physical Therapy, LLC is an out-of-network provider (does not bill or accept insurance, with the exception of Medicare). Donna Behr Physical Therapy, LLC will provide documentation to assist in obtaining full coverage.
- If I am covered by Medicare, I request payment be made to Donna Behr Physical Therapy, LLC for any services or goods rendered by Donna Behr Physical Therapy LLC. I authorize release of medical information about me to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services to Donna Behr Physical Therapy LLC. I also authorize payment of benefits from my secondary insurance carrier, if applicable, to Donna Behr Physical Therapy, LLC.
- I authorize the release of all medical records to the referring and family physician and to my insurance company, if applicable.
- I allow fax transmittal of my medical records, if necessary.
- I agree to pay all reasonable attorney fees and collection of costs in the event of default of payment of my charges.
- I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.
- I permit a copy of this authorization to be used in place of the original.
- This authorization may be revoked by me, in writing, at any time.

Acknowledgement of Receipt of Notice, Privacy Practices
Donna Behr Physical Therapy, LLC

I hereby acknowledge that I have been provided a copy of this medical practice's Notice of Privacy Practices. Karen Taylor Soiles, Privacy Officer

_____
Printed Name

_____
Signature Date

If not signed by patient, relationship to patient: □ parent or guardian of minor patient
□ guardian or conservator of an incompetent patient
□ beneficiary or person representing deceased patient