RIVER PARISH
Physical Therapy & Wellness

All policy information was made available to patient.

Financial Policy

I have read and understand the River Parish Physical Therapy & Wellness, LLC financial policy, agree to the terms and understand that I am ultimately responsible for payment of the health care services provided. I, as the patient, authorize payments of medical benefits to River Parish Physical Therapy and Wellness, LLC.

_____

Print Name of Guarantor (if applicable)

_____

Signature of Guarantor Date

Informed consent of Physical Therapy

I have read the consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorized the release of my medical information to appropriate third parties.

HIPPA

I consent to the use or disclosure of my protected health information (PHI) by River Parish Physical Therapy & Wellness, LLC for treatment, payment, and health care operations. I have read a copy of the Notice of Privacy Practices: HIPPA and understand I have a right to review it prior to signing this document.

Print name of patient: _____

Signature of patient: _____ Date_____