Actify Physiotherapy
The Orthopedic Specialists in Boca Raton

Authorization/Consent/Financial Policy

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION: Actify Physiotherapy is hereby authorized to disclose all or any part of the medical record of the patient named in the registration to such insurance companies or agencies as may be concerned with the payment of professional and/or facility costs of the patient named on this registration. The authorization is effective for three years from the date of service and may be revoked with written notification.

CONSENT FOR MEDICAL TREATMENT: The undersigned hereby consents to any training, therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of Actify Physiotherapy as to the results of any treatment given or performed.

USUSAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

SCHEDULING AND MISSED APPOINTMENTS: It is the patient's responsibility to make and confirm their appointments (date and time). We are unable to guarantee standing appointments but will make every effort to schedule appropriately so that a patient never has an extended wait to see a therapist. If you are unable to attend an appointment, we ask that you call 24 hours in advance to let us know. By calling us, you will allow us to make the appropriate changes to the schedule. ***A $75 cancellation fee will be charged for missed appointments without 24 hour notice.***

REGARDING INSURANCE: ***Actify Physiotherapy is not enrolled as a provider with any insurance company.*** The submission of the fees paid for each visit is the patient's responsibility, and does not dismiss the patient's responsibility for payment in full for each visit.

By my signature below, I recognize, understand and accept that I am ultimately financially responsible for any and all charges for services rendered by including, but not limited to, any services or fees not covered or denied by my insurance company. Additionally, I agree to pay all charges associated with the cost of collection, if my account becomes delinquent, including reasonable attorney's fees, court costs, finance charges and the legal rate of interest on the account until paid in full.

MEDICAL EMERGENCIES It is our policy to call 911 in case of medical emergencies.

I certify that I have read and understand fully the above information.

_____ _____ _____

Signature of Patient or Responsible Party | Print Name | Date

_____ _____ _____

Signature of Parent or Guardian | Print Name | Date