PHYSICAL THERAPY GROUP
COMMITTED TO EXCELLENCE

Informed Consent

I understand that the purpose of the treatment rendered by Physical Therapy Group, Inc. is to reduce the symptoms of my condition and to improve my ability to function on a daily basis. I understand that my medical record will be kept private and no information will be shared without my consent, except to my referring physician or to those I agree to.

Our Billing Policy

Physical Therapy Group, Inc. will pre-authorize your insurance coverage, but this is not a guarantee of benefits. In the event your insurance company does not cover any or all services, you should call your claim representative directly, and until further instruction we will set up payment arrangements. We will be happy to assist you with this process. **You are liable for any amounts not covered or paid by your insurance. All Co Pay's are due the day of service.**

I agree with the above policy and accept the conditions.

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Patient Signature Date

We accept Cash and Checks.

Our Attendance Policy,
To all patients we are committed to your full recovery. We will schedule your appointments in advance, at mutually convenient times. Please call and cancel if you cannot make your appointment and we can reschedule at that time. Failure to call will take you off our books until another appointment is scheduled.

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Medical Records Release

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE PHYSICAL THERAPY GROUP, Inc., AND OR THEIR BILLING DEPARTMENT TO FURNISH ALL INFORMATION THEY MAY HAVE REGARDING MY CONDITION WHILE UNDER THEIR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, BILLING AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS TO ANY PHYSICIAN, HOSPITAL, CLINIC, INSURANCE COMPANY OR ATTORNEY.

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Patient Signature Date