

**DynaPeak Fitness and Physical Therapy**  
**Consent and Statement of Financial Responsibility**

1. **Consent for treatment:** I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and considered necessary or advisable by my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.
2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel no show charge of \$30 or \$60 depending upon appointment type.
3. **RESPONSIBILITY FOR PAYMENT:** I acknowledge that in consideration of the services provided to me by DynaPeak, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide DynaPeak with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, copayment, co-insurance or charges not covered or denied by my health insurance, or other programs for which I am eligible.

Please note that refusal to sign this form does not change *responsibility* for payment in any way

4. **ASSIGNMENT OF BENEFITS:** I hereby assign DynaPeak all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.
5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that DynaPeak may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and DynaPeak's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received DynaPeak's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.
6. **HIPAA AUTHORIZATION:** In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

**7. CONSENT FOR EMERGENCY CONTACT INFORMATION**

Person to contact in case of an emergency:

\_\_\_\_\_  
\_\_\_\_\_  
Name Phone Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

\_\_\_\_\_  
Signature of Patient or Legally responsible Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Above

\_\_\_\_\_  
Date