Dynamic Life
Therapy & Wellness, PC

Consent for Treatment
I hereby give my consent to receive treatment by a licensed Physical Therapist, Occupational Therapist, Physical Therapist Assistant, and/or Fitness Instructor of Dynamic Life Therapy and Wellness, PC based on my individualized treatment and medical needs.

Authorization to Release Payment and Information
I authorize Dynamic Life Therapy & Wellness, PC to bill my insurance and release any medical information about me to my insurance carrier and its agents to determine benefits payable and process claims for services rendered. I authorize payment of authorized insurance benefits be made on my behalf to Dynamic Life Therapy and Wellness, PC for any services rendered.

Insurance Benefits Policy
I understand any estimate or quote by Dynamic Life Therapy and Wellness, PC is not a guarantee of coverage, benefits, or payment and is subject to change. Actual plan coverage and benefit payments are determined when a claim is received by insurance. Some insurances, including Medicare, have an annual cap or visit limit for outpatient therapy services each year. I understand I am responsible to inform Dynamic Life Therapy and Wellness, PC of any previous physical, speech or occupational therapy received during the calendar year. I understand if I fail to do so I will be expected to pay in full the billed amount not covered by Medicare, supplement, or private insurance.

Our Payment Policy
I understand I am primarily responsible for all non-covered expenses, which may include but not be limited to co-payments, co-insurance or deductibles. Balance on account is due upon receipt of statement, or payment arrangements can be set up with our office. I agree that failure to pay or set up payment arrangements after three (3) consecutive statements will result in the account being assigned to a collection agency for bad debt recovery.

HIPPA
The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPPA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Communicable Diseases
I understand that Dynamic Life Therapy and Wellness, PC staff and contractors cannot be held liable for any possible exposure to the Covid-19 virus or other communicable diseases.

By signing below, you certify that you have read and understand the above agreements.

_____
Signature of patient, parent/legal gaurdian or power of attorney

_____
Date

_____
Signature of witness/staff