Blue Sky Physical Therapy
155 S. Madison St Suite 303, Denver, Colorado, 80209 • Phone 303-388-1537 • Fax 303-388-4470

Patient Name: _____
First Name Middle Initial Last Name

CONSENT TO TREAT:
I agree and give my consent for Blue Sky Physical Therapy., P.C. to furnish physical therapy care and treatment considered necessary and proper in diagnosing and /or treating my physical condition.

ASSIGNMENT OF BENEFITS:
I hereby assign payment for services rendered directly to Blue Sky Physical Therapy, P.C. and authorize release of information necessary to process my insurance claims. I agree to pay all co-payments and coinsurances required, deductibles and any portion that my insurance will not pay. I understand that co-payments are to be made at the time of service. I understand that if this is a motor vehicle accident and the medical benefits are exhausted then financial responsibility reverts to my health insurance. If this account goes to collection, I will be responsible for all fees incurred. A $30.00 fee will be added for any returned checks.

We check insurance as a courtesy to our patients. **We do not guarantee the information provided to us is correct** and the insurance company may process claims differently than stated. The information provided is only a quote of benefits and is not a guarantee of payment. Therefore, you may be responsible for payments greater than originally quoted.

CANCELLATION/NO SHOW POLICY:
Unless cancelled at least 24 hours in advance, our policy is to charge **$50.00** for missed appointments per each half hour scheduled. We may have patients on a waiting list and your courtesy of a phone call allows us to schedule them. This cancellation charge is not covered or billed to your insurance company but is your sole responsibility to pay. A total of **three** cancellations and/or no shows may result in discharge from our practice and/or notification of your insurance company of non-compliance. Individuals who are more than 15 minutes late will be charged a cancellation fee and be required to re-schedule their appointment for another day.

RELEASE OF INFORMATION:
I authorize the release of my medical records, reports, x-rays, or diagnostic images to Blue Sky Physical Therapy, P.C. for the purpose of obtaining medical information relevant to my treatment. I authorize Blue Sky Physical Therapy to send copies of documents related to my treatment to my primary care physician and/or referring physician.

Acknowledgement of Receipt of Notice of Privacy Practices
I acknowledge that I have read the Notice of Privacy Practices from Blue Sky Physical Therapy, P.C. and understand it completely. (The notice is attached to the clip board, copies upon request)

By signing below, I acknowledge that I have read, fully understand and agree to all of the statements and policies of Blue Sky Physical Therapy set forth in this document.

Signature_____Date:_____