

My symptoms improve with _____

My symptoms worsen with _____

Please list any previous treatments for your condition, if any: _____

I authorize O'Neill Physical Therapy Services to release information from patient records to any insurer of the patient and to other agencies or individuals providing medical or social services to the patient. Consent is given for the release of information and records to O'Neill Physical Therapy Services from all other agencies or individuals from where the patient has received medical or social services. I hereby authorize the insurance company or law firm representing me to pay directly O'Neill Physical Therapy Services for services I've received. I understand that I am responsible to pay co-payments and deductibles at the time of service. I understand failure to pay the co-payments and deductibles will result in cancellation of my appointment and that I will be charged the cancellation fee. I understand that the charges may be more than my insurance company will cover and I am responsible for the balance due on my bill.

INFORMED CONSENT: I am aware that I am undergoing physical therapy. Benefits may include relief of pain and improvement of function. Risks may include temporary aggravation of symptoms, pain or other adverse effects. Should I note a change in my symptoms, I am responsible for informing my P.T. I consent to treatment including, but not limited to therapeutic exercises, electric stimulation, hot packs, cold packs, ultrasound, gait training, functional training, tapings, paraffin, biofeedback, traction, iontophoresis, joint & soft tissue mobilization and manipulation.

INTEREST: The undersigned agree to pay O'Neill Physical Therapy interest in the amount of 18% per annum (1.5% per month) on any balance which is 30 days past due. The returned check fee is \$30.00.

ATTORNEY FEES: The undersigned agree to pay O'Neill Physical Therapy attorney fees in the amount of 15% of the amount due O'Neill Physical Therapy pursuant to this contract in the event that the debt owed pursuant to this contract is placed in the hands of an attorney for collections, whether suit is filed or not, together with court costs and costs of collection.

I recognize that a 24 hour notice of cancellation of appointments is required. If I fail to give proper notice, I (not my insurance company) will be billed a \$30 fee.

SIGNATURE

_____/_____/_____
DATE
