



Pillars Physical Therapy
and Wellness Center

2nd Floor, Suite D, 307 87th St.
87th Street Plaza, Daly City, CA 94015
(650) 550-0050

CONDITIONS OF REGISTRATION

MEDICAL CONSENT

I, the undersigned patient do hereby request and consent to the performance of Physical Therapy and other diagnostic tests on me (or the patient named above, for whom I am legally responsible) by Pillars Physical Therapy and Wellness Center and/or their associates who now or in the future treat me while at the clinic or office mentioned above or any other office clinic.

BILLING POLICY, RELEASE AND AUTHORIZATION, CANCELLATION POLICY

I authorize Pillars Physical therapy to bill me insurance company directly for covered portion of charges, and I authorize payment of medical benefits directly to Pillars Physical Therapy. I authorize Pillars Physical Therapy to release any medical or other information to process this claim.

I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance, or co-payment, and any charges not reimbursed by my insurance carrier. I agree that it is my sole responsibility to notify the office of current coverage address, and telephone numbers.

I understand that some insurance companies require medical or administrative authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand and I am responsible for knowing and meeting the requirements of the insurance plan.

If it is necessary to employ a collection agency and/or attorney to enforce or to collect a judgment based on this agreement, the patient will be responsible for payment of the fees promised including interest, court costs and attorney fees.

I understand that cancellation of my appointment must be made within 24 hours. A cancellation made before 24 hours not due to emergency or a no-show will cause a cancellation charge on my account.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

RELATIONSHIP TO PATIENT: _____