Financial Policy and Release of Information Authorization

* I consent or I am signing for the minor named on this form to be examined and treated by BrownStone Physical Therapy or a representative thereof.

* I authorize BrownStone Physical Therapy to release to the referring physician and/or primary care physician, medical vendor, and insurance carrier the necessary information pertaining to my treatment as requested to expedite claim processing, payment and/or further authorization for treatment and/or medical equipment that are permitted under HIPPA regulations without written authorization.

* I agree that (regardless of my insurance status), I am ultimately responsible for any balances on my account for professional services rendered. I request that payment of authorized services be made to BrownStone Physical Therapy for services rendered.

* I understand that if my insurance company requires a copayment; that copayment is my responsibility and payment is due at the time of service.

* I understand that a $25 fee will be charged for all returned checks.

* At BrownStone Physical Therapy we are committed to providing you with excellent, quality physical therapy services. We ask that you make every effort to arrive on time for scheduled appointments. Please try to provide 24 hours notice for appointment cancellations. NO SHOW visits will be charged a $50.00 fee. This fee will be assessed regardless of insurance type and payment is the responsibility of the patient, not the insurance company.

* I hereby authorize BrownStone Physical Therapy to disclose a verbal message pertaining to my appointments to a family member or by leaving a message on my home/cell phone answering machine.

I have read and agreed to the Release of Information and Financial Statements listed above. In the event the patient is a minor, by signing for the so named minor, I am agreeing to the statements listed above.

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by BROWNSTONE PHYSICAL THERAPY, PC. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPPA privacy regulations. The purpose of the photographic/video images, and/or

testimonial will be used for Social Media and/or Marketing. I understand that I may revoke this authorization at any time but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires upon written notice. I understand that the practice cannot condition treatment on whether or not I sign this authorization.