

**Birmingham Physical Therapy & Sports Medicine**  
**3140 Cahaba Heights Road, Suite 201**  
**Vestavia Hills, AL 35243**

Phone (205) 298-9101 Fax (205) 298-9103

Consent for Physical Therapy Treatment  
Authorization for Release of Information

**Consent for Physical Therapy:** I hereby voluntarily consent to the rendering of care for a condition requiring physical therapy services. I understand that diagnosis and treatment may involve risks or injury. I acknowledge that no guarantees have been made to me as a result of examination or treatment. I hereby authorize Ellen Hamilton and Andrea Abercrombie, **Birmingham Physical Therapy & Sports Medicine, Inc.**, to retain any records for use, for research and for teaching purposes.

**Consent for Blood Testing:** I give my permission for a sampling of my blood to be tested for infectious disease in the event that a therapist or other employee becomes exposed to my blood or bodily fluid.

**Authorization for Release of Information:** I authorize my referring physician to release any information necessary for my treatment at **Birmingham Physical Therapy & Sports Medicine, Inc.**

**Medicare, Title XVIII:** The information that I have given for payment application under **Title XVIII** of the Social Security Act is correct. I authorize **Birmingham Physical Therapy & Sports Medicine, Inc** to release any information to the Social Security or its carriers to gather information needed to file this Medicare claim and request payment on my behalf.

**Payment of Services:** I authorize any release of medical information that is required for payment owed by me to **Birmingham Physical Therapy & Sports Medicine, Inc.** I agree that **Birmingham Physical Therapy & Sports Medicine, Inc** will not be responsible for confidentiality of any documents released to any insurance carrier or other entity responsible for payment of my healthcare costs. I authorize payment from any third payer to be made directly to **Birmingham Physical Therapy & Sports Medicine, Inc.**

I understand that I am financially responsible to pay all costs and fees to **Birmingham Physical Therapy & Sports Medicine, Inc** that are not covered by my insurance company. I agree to pay collection costs including attorney fees incurred by **Birmingham Physical Therapy & Sports Medicine, Inc** related to collecting costs and fees charged to me for all services rendered and goods provided in the event of failure to pay all debts.

We are committed to provide the best service possible for you. Please give us a 24 hour cancellation notice if you are unable to make your scheduled appointment, so that we might notify other patients who may need treatment.

\_\_\_\_\_ **I understand there is a \$30.00 fee for missing an appointment without 24 hour notice.**

Patient: \_\_\_\_\_  
(or signature of parent if patient is a minor)

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_