1509 West Orange Blossom Trail
Apopka, FL 32712-2688
Phone: (407) 814-0436
Fax: (407) 814-0818

Consent for Treatment

I, the undersigned, do hereby authorize Performance Rehabilitation to administer treatment as is necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that as a courtesy Performance Rehabilitation will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Performance Rehabilitation. I understand that I am ultimately responsible for payment of all services rendered, unless otherwise provided by law.

Deductibles/Percentage pays and/or Co-Payments

Co-payments and deductibles are to be paid at time of service, unless prior arrangements have been made with the business coordinator. Percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the date on the invoice. Patients are to keep payments current.

Cancellation/No-Show Policy

I understand that cancellations should be made within 24 hours prior of their scheduled time, unless extenuating circumstances prevent otherwise. A $35.00 fee may be enforced for no shows or late cancellations. You may be required to leave a credit card authorization or deposit to insure payment. Enforcement of the above Cancellation/No-Show is at our discretion.

Notice Of Privacy Practices

I confirm that I have received a copy of Performance Rehabilitation's Notice of Privacy Practices.

By signing below you are agreeing to all the above terms and conditions.

Patient or Legal Guardian's Signature: _____

Date: _____