BLAKE Physical Therapy

Specializing in Orthopaedic and Sports Injuries

4820 Lincoln Blvd, MDR, 90292 • 1714 17th St, Santa Monica, 90404
Tel (310) 822-0041 Fax (310) 822-0049 www.blakephysicaltherapy.com

Please PRINT: _____

Patient Name LAST FIRST

Assignment of Benefits & Release of Information

I hereby assign payment for services rendered to me (or my dependent) to Blake Physical Therapy, PC / Jeffrey Blake, PT. I authorize them to disclose all or any part of my (or my dependents) record to any person or corporation which may be liable for all or part of the charges.

_____ _____

Patient or Guardian Signature Date

Payment Policy

- You are financially responsible for all services not covered by your insurance company.
- At each visit, you will be expected to pay the amount verbally quoted to us by your insurance company, including outstanding deductibles.
- We accept cash, check, Visa or MasterCard.
- Accounts with a past due balance over 30 days will be charged a monthly interest rate of 1.5% plus a monthly $20 late / administrative fee.
- There is a $25 fee for returned checks.

I have read and understand the above payment policy.

_____ _____

Patient or Guardian Signature Date

Cancellation Policy

- Cancellations must be made at least 24 hours prior to your appointment time.
- Late cancellations and "No Show" appointments will be charged $50. This is not billable to your insurance company.

I have read and understand the above cancellation policy.

_____ _____

Patient or Guardian Signature Date

Consent to Treat (If patient is a minor)

I, _____ give Blake Physical Therapy permission to treat the above named patient as needed.

_____ (Signature)