Central Bucks Physical Therapy LLC
PELVIC AND ORTHOPEDIC PHYSICAL THERAPY

Patient Agreement For Services and Release of Information

1. **Authorization for Billing Service Communication**:
   I authorize the release of my information to WebPT for billing purposes (filing claims/patient balance billing/etc.). I authorize any contact from WebPT in effort to collect any outstanding balances. Your ***signature*** below indicates your authorization for this activity.

2. **Authorization for Patient Communication:**
   I authorize the provider of service to contact me via phone (home or cell), text, email or other means at home/work for purpose of: appointment scheduling or rescheduling, billing, releasing medical information and/or to return messages I left related to my condition.
   I authorize you to leave a message on my cell, home answering machine or with a family member answering the phone.
   I do not want you to leave a message with ______________________________.
   If you choose not to authorize this information, your decision will have no adverse effect on your care or relationship with our staff.
   Your ***signature*** below indicates your authorization for this activity.

3. **Treatment Authorization:**
   Since my state of health requires the services of Central Bucks Physical Therapy, LLC (CBPT): of my free will, I agree to actively participate in these services such as evaluation, assessment, treatment, self care, manual therapy, therapeutic exercises and home program given by the physical therapy staff of CBPT. I understand that CBPT has specific policies and that these policies include that services can be stopped at any time by my request, the request of my physician and/or the decision of CBPT. I agree to follow all the terms of these CBPT policies.
   Your ***signature*** below indicates your authorization for this activity.

4. **Statement of Non-Discrimination:**
   CBPT and the patient agree that services are given without regard to race, color, sex, age, national origin or handicap.
   Your ***signature*** below indicates your agreement of this statement.

5. **Privacy Practice Acknowledgement:**
   I acknowledge the privacy practice is posted in CBPT and receipt of the privacy practices of CBPT.
   Your ***signature*** below indicates your authorization for this activity.

I acknowledge the above statements and authorize those activities.

Patient/Guardian Signature: ______________________________ Date: ________________

Print Name: ______________________________

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