PHYSIOTHERAPHY NEW MEXICO
9 Frasco Way
Santa Fe, NM 87508

SIGNATURE ON FILE

Please read and initial each statement:

_____ I authorize use of this form on all insurance submissions.

_____ I authorize release of information to all my insurance companies.

_____ I understand that I am responsible for my bill.

_____ I permit a copy of this authorization to be used in place of the original.

_____ I understand that I am responsible for co-pay at the time of service.

_____ Physiotheraphy New Mexico requires a 24-hour notice for cancellations. There will be a charge of $100 for a missed appointment.

_____ I consent to treatment and will participate in the appropriate procedures as described by my therapist.

NAME (please print): _____

SIGNATURE: _____

Date: _____