



PHYSIOTHERAPY NEW MEXICO
9 Frasco Way
Santa Fe, NM 87508

SIGNATURE ON FILE

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Please read and initial each statement:

- I authorize use of this form on all insurance submissions.
- I will NOT submit my bills to Medicare and/or supplementary insurance.
- 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.
- Physiotherapy 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: _____