



PLEASE NOTIFY OFFICE OF CANCELLATION NO LATER THAN 24 HOURS PRIOR TO SCHEDULED APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A \$45.00 CHARGE AND PAYMENT IS EXPECTED ON YOUR SUBSEQUENT VISIT.

I hereby give my consent to the performance of whatever routine evaluative procedures and/or treatments, which may be deemed advisable at the discretion of the Physical Therapist. I understand that all Physical Therapists and their ancillary staff are independent contractors and are not employees of The Marsh.

PATIENT SIGNATURE : _____ DATE : _____

SIGNATURE OF PATIENT'S LEGAL GUARDIAN : _____

ASSIGNMENT OF BENEFITS

I request payment of authorized Medicare and/or health insurance benefits for all services furnished me by Merz Physical Therapy I guarantee payment of the charges not covered by this authorization.

PATIENT SIGNATURE : _____ DATE : _____

WAIVER AND RELEASE

I recognize the risk of injury in any program at The Marsh and I am participating upon understanding that use of The Marsh's facilities is undertaken at my own risk, and that Merz, Inc. shall not be liable for any claims, demands, injuries, or damages arising out of, or connected with the use of such facilities, or the premises where the program is conducted, including those damages resulting from acts of The Marsh, its agents and employees. Accordingly, I hereby release and discharge Merz Physical Therapy. By signing this waiver and release, I acknowledge that I have read all of its provisions and understand all of the terms.

PATIENT SIGNATURE : _____ DATE : _____

I am aware of my personal benefits and responsibility with my specific insurance plan and will submit in writing to the billing department at Merz Physical Therapy any specific requirements necessary for claim processing or any changes in my coverage. I am also aware that these fees may be due at the time of service and that my patient account may be assessed a late fee for a balance 30 days past due.

PATIENT SIGNATURE : _____ DATE : _____