GESIK
PHYSICAL THERAPY

677 Ala Moana Blvd. • Suite 725 • Honolulu, HI 96813
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CONSENT FOR CARE AND TREATMENT

I, _____, do hereby agree and give my consent to Gesik Physical Therapy to furnish medical care and treatment considered necessary and proper in treating my physician's diagnosed physical condition.

I, hereby assign all medical benefits for treatment provided in the clinic to which I am entitled, including Medicare, private insurance, worker's compensation insurance, motor vehicle insurance, and other third party payers to Gesik Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize the clinic to release all information necessary including medical records, to secure payments.

In-office co-pays are an **estimate** of patient's responsibility. You will be responsible for the remaining amount after the insurance has paid. The clinic will bill your insurance carrier for you, provided we have complete insurance information at the time of the visits. Co-pays/percentages and deductibles are determined by your insurance company. Questions regarding these should be directed to them.

I agree to give at least **24-hour** notice for all cancellations. I understand that failure to give proper notification may result in a fee of $40.00 and/or suspension of services.

DATE:_____

I, X_____, declare that I have read and understand the above information and am responsible for the payment of my account in a timely manner.