



Austin Manual Therapy

A S S O C I A T E S

Physical therapy that's far from ordinary yet close to home.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Austin Manual Therapy Associates. I also authorize Austin Manual Therapy Associates or insurance company to release any information required to process my claims.

I understand that it is my responsibility to know my insurance benefits and whether or not the services I am about to receive are a covered benefit. I understand and agree that I will be financially responsible for any cost-share or balance due that AMTA is unable to collect from my insurance carrier due to any limitations on my plan coverage. If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.

I am aware of the no show/late cancellation policy and understand and agree that a fee of \$35/half hour or \$70/hour appointment slot will be charged to my account should I be unable to comply with this policy. I further understand that this fee is not covered by my insurance carrier.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and I understand my rights as stated therein.

Parent/Guardian Signature

Date