DEVINNEY CZARNECKI PHYSICAL THERAPY, P.C.
6020 W. Maple Ste 500, West Bloomfield MI 48322 (248)851-6999 FAX (248)851-6898

Patient Financial Responsibility & Authorization Statement

and HIPAA Notification and Consent

I hereby authorize DeVinney Czarnecki Physical Therapy, P.C. to provide me with the treatment ordered by my physician.

I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to DeVinney Czarnecki Physical Therapy, P.C. and all insurance and settlement benefits due me to the full extent of my financial obligation to said clinic.

I understand my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment for charges incurred.

I acknowledge that I have been informed of the Notice of Privacy Practices, a copy has been made available to me, and I consent to the disclosures of my information, which are deemed necessary in connection with my treatment.

We reserve the right to change the terms of our notice of privacy practices and to make the new notice provisions effective for all protected health information that we maintain. If we change our information practices, we will post the revised notice in the office and provide you with a copy upon request.

Print Name Signature Date

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