



RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I hereby authorize In Harmony and its staff to render Physical Therapy and/or other services as requested by my physician to the above patient/myself and agree to assume all financial obligations incurred for such services. I additionally authorize In Harmony to release information to my physician as necessary. I permit a copy of this authorization to be used in place of the original.

X _____
Patient Signature / Date

Representative's Signature if patient unable to sign / Date

PRIVACY PRACTICES

I acknowledge that I have reviewed and been offered a copy of the Notice of Privacy Practices. I have been instructed to contact the privacy official at 713-392-1303 at any time with questions/concerns I may have now and/or in the future regarding this notice.

I authorize the following people to participate in all conversations and management of my care.

Relationship

Relationship

Staff/therapists/agents for In Harmony PT MAY MAY NOT leave messages on my telephone voice mail system.

X _____
Patient Signature / Date

Representative's Signature if patient unable to sign / Date

Staff Signature / Title / Date