AUTHORIZATION ADDENDUM

I hereby authorize my Medicare and/or other Insurance benefits for services furnished to be paid directly to **STUDIO BRAVA PHYSICAL THERAPY, INC.** I consent to treatment necessary for the care of the below named patient. I authorize the release of my medical records to my referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I acknowledge full financial responsibility for services rendered by **STUDIO BRAVA PHYSICAL THERAPY, INC.**, for all charges whether or not they are covered by insurance. I authorize transfer of all unpaid accounts to my Visa, Master Card, or American Express account(s) after 30 days from the date of service. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payment be made to **STUDIO BRAVA PHYSICAL THERAPY, INC.,** should they elect to receive such payment.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Visa/MC/AEx Number	Exp Date	Sec Code	Zip Code
_____	_____	_____	_____

SIGNATURE_____DATE_____

PRINT NAME _____DATE_____