11110 Ohio Avenue, #105
Los Angeles, CA 90025-6345

AUTHORIZATION ADDENDUM

I hereby authorize my Medicare and/or other Insurance benefits for services furnished are paid directly to **STUDIO BRAVA PHYSICAL THERAPY, INC.**
I consent to treatment necessary for the care of the above named patient.
I authorized 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 authorized transfer of all unpaid accounts to my Visa, Master Card, or American Express account(s) after 120 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 authorized 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.

SIGNATURE_____DATE_____

PRINT NAME _____DATE_____