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TheraPhysical

PATIENT INFO

Last Name _____ First Name:_____

By my signature below, I am requesting that my doctor, Magdalena Buczek, DPT, reduce normal and customary fees to allow me to receive physical therapy care. My financial circumstances are such that I am unable to pay the customary fees.

I recognized that any agreement made to assist me is purely confidential and that my financial arrangement would be different than that which is standard in this office.

_____ **Patient Initials.** This is a financial hardship agreement not a guarantee of a "cure". No doctor can or should the response of any patient to any treatment.

Patient Signature _____ **Date** _____

Witness Signature _____ **Date** _____