CONSENT FOR CARE &TREATMENT

I, the undersigned, do hereby agree and give my consent for **Physical Therapy Works** to furnish medical care and treatment to ____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian /Responsible Party __________________________________**Date**______________

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to Physical Therapy Works. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medial records, to secure payment.

Patient/Guardian/Responsible Party ___________________________________**Date**_______________

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal ***usual and customary fee schedule,*** you will be responsible for the difference remaining. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to Physical Therapy Works. The above does not apply for those patients that are considered Workers' Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS:

Estimated Insurance Benefits:

____

Arrangement for payment of patients share:

____

Any Balance to be billed.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

Information Privacy: Physical Therapy Works will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____ _______________________

Patient/Guardian/Responsible Party **Date**

____ _______________________

Center Representative / Witness **Date**