provision
PHYSICAL THERAPY

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give consent for Provision Physical Therapy to furnish care and treatment

To (patient) _____ that is considered necessary and proper in diagnosing or treating my/his/her condition.

RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Provision Physical Therapy may make available certain basic information about the patient in accordance with HIPAA regulations, including name, address, age, sex, general description of the reason for treatment, general nature of the injury, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Provision Physical Therapy for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Provision Physical Therapy may disclose portions of the patients record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Provision Physical Therapy's charges, including but not limited to government agencies (e.g., Medicare, Medicaid, insurance companies, health care service plans, or workers compensation carriers). By signing below, I acknowledge that I have received Provision Physical Therapy's Notice of Privacy Practices.

BENEFIT ASSIGNMENT: I hereby assign medical benefits to which I am entitled, including Medicare, private insurance, and third party payers, to Provision Physical Therapy. A photocopy of this assignment is to be considered as valid as the original.

FINANCIAL AGREEMENT: The patient is responsible for providing payment at time of service for all co pays, deductibles, coinsurance and any remaining balance due from services that are not covered by the patient's insurance carrier. I understand 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 original charges, interest, collection agency fees, and attorney fees.

ASSIGNMENT OF INSURANCE BENEFITS: It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We have called your insurance company for estimated insurance benefits, and they are reflected on the "Verification of Benefits" form.

CANCELLATION AND MISSED APPOINTMENT POLICY: Failure to provide 24 hours advanced notice of cancellation will incur a $40 fee automatically charged to your account. In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care. In those rare cases, we will inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

WORKER'S COMPENSATION CLAUSE: The above financial policy does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied, you will be held responsible for any remaining balance on your account. At that time, our Financial Policy will apply to you.

I have read the above Information and understand my responsibilities.

_____

Patient's Name (PRINT)

_____

Patient / Guardian Signature Date

_____

Witness / Employee Signature Date