



## 1. CONSENT TO TREATMENT

I (or the undersigned acting on behalf of the patient) consent to medical care and treatment including but not limited to: diagnostic tests, examination and/or treatment that are relate as they relate to physical therapy sessions at Specialized Physical Therapy PC (to be referred to as SPT in this document). I acknowledge that no guarantees have been made to me as to the results of diagnosis, treatments, tests or exams.

## 2. ASSIGNMENT OF INSURANCE BENEFITS

- a. I assign to Specialized Physical Therapy, PC (SPT), subject to acceptance, all right, title, and interest, in and to benefits payable, an authorize direct payment to SPT, all insurance benefits. I agree to pay SPT for charges not paid pursuant to this assignment.
- b. I assign to physical therapists, occupational therapists and athletic trainers, providing services in connection with the episode(s) of treatment to which this form applies, subject to acceptance, all right, title, and interest, in and to benefits payable, and authorize direct payments to Specialized Physical Therapy PC, all health insurance benefits. I agree to pay for charges not paid pursuant to this assignment.
- c. I agree that in the event a credit balance results from insurance payments under this assignment, SPT may apply the credit balance to any other accounts for which I am financially responsible.
- d. I agree that by signing as the patient and/or responsible party, that in consideration of the services rendered to the patient, I obligate myself and/or the patient to pay the accounts of SPT in accordance with their approved charges as determined by Medicare and other third party payers, with the understanding that the patient and/or responsible party shall pay any deductible and co-insurance amounts, together with any charges for professional services not covered by any such third party payers.
- e. I agree that I am responsible for obtaining any prior authorizations or utilization review approvals required by my insurance company.

## 3. AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize SPT, and any allied health professional to furnish from the medical records arising from services rendered during the episode(s) of care to which this form applies, photocopies of such records and/or information and excerpts from such records to physician(s), their assistants, or designees, and/or allied health professionals, any third-party payer (whether an insurance company, government agency, or self-insured employer), any utilization review organization (whether sponsored by SPT, an insurance company, government agency, or self-insured employer) and/or any transferee health care facility and/or agency, for the purpose of obtaining payment of SPT for services rendered during this episode of care, performing utilization review, and/or post visit care and treatment.

## 4. MEDICARE BENEFITS: SOCIAL SECURITY ACT

Authorization to Release Information and Payment Request:

- a. I certify that the information given by me in applying for payment under the title XVIII of the Social Security Act is correct.
- b. I authorize the release of all records or photographic reproductions thereof, to/from the Social Security Administration and its intermediaries, providers, or carriers which are required to act upon this or any related Medicare claim.
- c. I authorize any SPT based provider to submit a claim to Medicare or SPT to submit a claim on behalf of SPT based therapists with the understanding that I will be responsible for the entire unreimbursed balance of the claim to the extent permitted by law.

I understand that I am responsible for any medical insurance deductible and coinsurance and the cost difference of any special accommodations made at my own request, per consent provided on a separate Advance Beneficiary Notice form.

## 5. RELEASE OF RESPONSIBILITY FOR PERSONAL PROPERTY:

- a. I understand and agree that SPT maintains facilities for the safekeeping of money and valuables, and SPT shall not be liable for the loss or damage of any money, jewelry, glasses, dentures, documents, fur coats, and fur garments or other articles of unusual value unless placed therein, and shall not be liable for the loss or damage to any other personal property unless deposited with SPT for safekeeping.
- b. I accept full responsibility for all property kept in my possession.

## 6. RESEARCH:

SPT may perform teaching and research functions. Patient records related to your care at SPT may be used in research with the approval of an Institutional Review Board (IRB) and consent as required by federal regulations. They may also be reviewed by physical therapy students at SPT as is traditionally considered to be a necessary component of the educational process.

Please Initial Page 1 of 2: \_\_\_\_\_



**7. COLLECTION AGENCY FEES:**

If your account is forwarded to a collection agency due to non-payment, a fee of 50% of the total bill will be added and will be the responsibility of the patient.

**8. NO SHOW / CANCELLATION POLICY**

There will be a charge of \$50.00 for appointments missed without cancellation or if the appointment is not cancelled 24 hours in advance. Emergency situations will be considered on an individual basis. If the patient is more than 10 minutes late we cannot guarantee service. The patient will have the option to reschedule.

**9. FINANCIAL AGREEMENT:**

I agree, by signing as the patient and/or responsible party, that in consideration of the services rendered to the patient that I obligate myself and/or the patient to pay the account(s) of SPT and any individual physical therapists, or allied health professionals rendering services in connection with this episode(s) of care, in accordance with regular rates and established billing policies of SPT and such other providers. I further agree to grant SPT and such provider's permission to obtain a credit rating report if applicable.

**I agree, by signing as the patient and/or responsible party, that I will pay any late fees associated with payment of this account postmarked later than due date as specified on mailed statements. I understand that late fees will be applied and enforced on accounts for which payment arrangements have not been made or which are not settled by 60 days from the billing date.**

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, HAS RECEIVED A COPY OF THIS DOCUMENT, AND IS THE PATIENT, OR IS DUTY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

X \_\_\_\_\_  
Signature of Patient

Date of Signing \_\_\_\_\_

X \_\_\_\_\_  
Signature of patient's Representative

Time of Signing \_\_\_\_\_

\_\_\_\_\_  
Representative's Relationship to Patient

Witness \_\_\_\_\_

If Patient is unable to sign, state reason: \_\_\_\_\_

IT IS UNDERSTOOD THAT THIS AGREEMENT SHALL TAKE EFFECT UPON REGISTRATION EVEN THOUGH IT MAY BE SIGNED PRIOR THERETO. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.