CONSENT FOR CARE AND TREATMENT:

I, the undersigned, do hereby agree and give my consent to **Contact Physical Therapy** to provide medical care and treatment to **(patient's printed name)** _____, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Patient/Guardian/Responsible Party Signature _____ Date _____

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION:

I authorize **Contact Physical Therapy** to release to my insurance company any medical information necessary to process claims for treatment that I and/or my dependent(s) receive under their care in order to secure payment. I authorize payment of any insurance benefits for physical therapy services be paid directly to Contact Physical Therapy.

Patient/Guardian/Responsible Party Signature _____ Date _____

FINANCIAL POLICY / NOTIFICATION OF PATIENT RESPONSIBILITY:

Contact Physical Therapy will bill your insurance carrier solely as a courtesy to you. If any payment is made directly to you for services billed, you recognize an obligation to promptly submit same to Contact Physical Therapy.

It is our policy to collect your co-payments, co-insurances, and/or any unmet deductible amounts from you at the time of service. In the event that a check is returned for Non-Sufficient Funds, a $25.00 service fee will be charged to you.

We have verified your Physical Therapy/Occupational Therapy benefits with your insurance company, based on the information provided by you. Please be advised that your insurance company has the disclaimer that this is a verification of benefits only, and not a guarantee of payment. Benefits/payments are determined once the claim is received. We do not accept responsibility for the accuracy of the information provided by your insurance company. We recommend that you contact your insurance company directly if you have any further questions or concerns regarding your benefits.

The following is an **estimate** of the amount(s) you are responsible for and your benefits provided to us by your insurance company:

Co-pay per visit:	Co-Insurance per visit (estimate only):	Deductible: Amount Remaining:	Visit or Dollar Maximum:	Additional Information, if provided:

Please Note: Coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. Any remaining balance due will be billed to you after additional information is received from your insurance company.

Please verify that you understand your financial responsibility by signing and dating this form:

I understand and agree that if I fail to make any of the payments I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Patient/Guardian/Responsible Party Signature_____ Date _____

Clinic Representative _____ Date _____