PREMIER
PHYSICAL • THERAPY

CONSENT FOR CARE AND TREATMENT

I agree and give consent for Premier Physical Therapy to furnish rehabilitative treatment, and medical care considered necessary and proper in diagnosing or treating physical and mental condition(s).

FINANCIAL POLICY STATEMENT

We provide you with an **estimated payment** amount which is due at the time of your visit. As a courtesy to you, we will submit to your insurance carrier, however, if the insurance company or financially responsible party does not pay for the services, you will be responsible for payment. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If 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 company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same to Premier Physical Therapy. I understand and agree that if I fail to make all of the payments for which I am responsible, promptly, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

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

CONSENT TO CONNECT

You agree that, for us to service your account or to collect any amounts you may owe, we may contact you by sending text messages, e-mails or telephone, based on the methods of contact you have provided. This may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, which could result in charges to you.

WORKER'S COMPENSATION ACCOUNTS

Be advised that 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.

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 payers to Premier Physical Therapy. A copy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

NOTICE OF PRIVACY/CONFIDENTIALITY

As a patient of Premier Physical Therapy, you have a right to the privacy/confidentiality act, and the right to view your medical records according to the regulations of the HIPAA act by the Department of Health and Human Services. HIPAA policies are posted at the clinic Please advise the staff if you have any problems or questions.

I UNDERSTAND MY RESPONSIBILITIES FOR THE PAYMENT OF MY ACCOUNT. When deemed appropriate by PREMIER PHYSICAL THERAPY, a photograph may be taken to document my status.

_____ _____

Patient/Guardian/Responsible Party Date