SPIER Physical Therapy, P.C.

Consent for Care and Treatment

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

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 ***SPIER*** **Physical Therapy**. A photocopy of this Assignment shall be as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records, to secure payment. I further authorize release to any physicians, hospitals, or others who may require such records in connection with my current condition.

Financial Policy Statement

I agree to pay promptly and fully all charges for services provided by ***SPIER*** **Physical Therapy**, at its regular rates and terms. ***SPIER*** **Physical Therapy** will bill my insurance company as a courtesy to me and will bill me on a monthly basis for any balance due after insurance payments and adjustments have been applied. I further agree to pay any charges, which for any reason, are not covered or not promptly paid by insurance. In the event that my insurance company requests a refund of payments made, I will be responsible for the amount of money refunded to my insurance company.

I understand that it is my responsibility to obtain any prior approvals required by my insurer, and to take all other steps to qualify for insurance coverage. I will determine whether my insurer requires pre-certification before I receive therapy services.

If any payment is made directly to me for services by ***SPIER*** **Physical Therapy**, I shall promptly remit the same to ***SPIER*** **Physical Therapy**.

The above does not apply for those patients that are considered worker's compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible to 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. A service charge of 1% per month will be added to all charges which remain unpaid after 90 days.

*I understand and agree that if I fail to show for any scheduled appointment or fail to cancel a scheduled appointment, I, (the patient) shall pay a **"no show" fee of $35.00**, which sum shall be in addition to any other amount due. Spier Physical Therapy will use its' discretion to discharge any patient who is not compliant with stated plan of care (e.g. 3 missed or cancelled appointments in a row). Notice must be given **prior** to visit, 24 hour notice preferred.*

Continuing Outpatient Care

In some cases, proper treatment of a medical condition requires continuing treatment or diagnosis over a course of repeated outpatient visits. In such cases, the consent and agreements contained here shall apply to all repeat visits and all continuing treatment and diagnosis for the same condition.

_____ _____

Signature Date

_____

If signing for patient, state relationship & authority

_____ _____

Center Representative/Witness Date