CONSENT FOR CARE AND TREATMENT:

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

Patient/Guardian/Responsible Party Signature ____ Date _______________

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION:

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

Patient/Guardian/Responsible Party Signature ____ Date _______________

<u>Privacy Practices:</u> By initialing here, I acknowledge that I have received a copy of APEX Physical Therapy's Notice of Privacy Practices and have been provided an opportunity to review it. _______
(initial here)

<u>NO SHOW/CANCELLATION POLICY:</u> In order to provide the highest quality of care to our patients we require a 24 hour notice for canceling or rescheduling appointments. Failure to do so will result in a $30 charge. _______
(initial here)

FINANCIAL POLICY / NOTIFICATION OF PATIENT RESPONSIBILITY:

APEX Physical Therapy will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event your insurance 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, you recognize an obligation to promptly submit same to APEX Physical Therapy.

****Your insurance company requires us to collect your co-payments, co-insurances, and/or any unmet deductible amounts from you at the time of service. When you provide a check as a payment, you authorize us to make a one-time electronic debit from your account or to process the payment as a check transaction.**** If we do not collect these amounts, we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment.
In the event that a check is returned for Non-Sufficient Funds, a $30.00 service fee will be charged to you.

We have verified your Physical Therapy/Occupational Therapy/Speech 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. The following is the amount you are responsible for and your benefits provided to us by your insurance company:

Co-Payment $ ___________ per visit or Co-Percentage _____________% per visit

Deductible Amount $ _______________ Deductible Amount Met $ _______________ Max Out of Pocket $ _______________

Max Visits/Days ______________ per ____ Max $ Amount ____________________

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 ____________