CITY PHYSICAL THERAPY, PC

Consent for Care and Treatment

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

Patient/Guardian Signature: _____ **Date**: _____

Benefit Assignment and Release of Information

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to City Physical Therapy, P.C. A photocopy of this assignment is to be as valid as the original. I, herby authorize said assignee to release all information necessary including Medical Records, to secure payment.

Patient/Guardian Signature: _____ **Date**: _____

Privacy Practices

I understand that City Physical Therapy, P.C. will use protected health information (PHI) for the purpose of treatment, payment, and heath care operations. I have been presented with the City Physical Therapy, P.C. Notice of Privacy Practices.

Patient/Guardian Signature: _____ **Date**: _____

Financial Policy Statement

City Physical Therapy will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance company does not remit payment within 60days, the balance will be due in full from you. In the event that 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 an obligation to promptly remit same to City Physical Therapy, P.C.

If you pay by check and your check does not clear, you will be charged an additional "Bounced Check Fee" of $50 in addition to any bank charges that we incur.
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 colleting monies owed, including court costs, collection agency fees and attorney fees.

Estimated Insurance Benefits:

_____

_____

Estimated Patient Payment: Deductible: _____

Copay/Coinsurance: _____

Arrangements made for payment of patient's share: _____

Patient/Guardian Signature: _____ **Date**: _____