**APPROVALS and ACKNOWLEDGEMENTS:**

## CONSENT FOR CARE and TREATMENT

- By signing this form below, I give consent for Exclusive Physical Therapy to furnish medical care and treatment considered necessary in treating my physical condition.

## RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

- All information provided on this form is true and correct to the best of my knowledge.
- I give permission to Exclusive Physical Therapy to RELEASE and/or OBTAIN information, both verbal and written, contained in my medical record and other related information TO or FROM my insurance company, case manager, employer, school, other healthcare provider, referring physician and/or rehabilitation nurse.
- I authorize direct payment to Exclusive Physical Therapy for services rendered.

## PAYMENT GUARANTEE

- I expressly guarantee payment of the account and agree to pay any charges left unpaid in whole or in part by the insurance company for services rendered by Exclusive Physical Therapy to the named patient on page one of this form.
- I, the patient and/or guardian, am ultimately responsible for the account balance.

## MEDICARE PATIENTS

- You may NOT seek treatment in an outpatient facility at the same time you are obtaining IN-HOME CARE.
- Due to Medicare requirements, it is YOUR responsibility to see your physician and provide a NEW referral prescription to our office.
- If we do NOT receive a new referral prescription from your physician as required, Medicare may deny payment of services and you could be financially responsible for therapy provided outside of the referral dates on your prescription.

**NOTE:**

- You may call the phone number on the back of your insurance card to find out your benefits for physical therapy if you do NOT know them.
- We will call your insurance company as a courtesy to you but that does NOT guarantee payment.

**Please Read and Initial:**

☐ **By my INITIALS, I understand that I could be charged $65.00 if I DON'T give a 24 hour notice to CANCEL my appointment OR for a "NO-SHOW"**

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| • By my signature, I certify that I have read, understand and agree to the above statements and information. | Authorizing Signature of PATIENT | Date |
| Printed Name of Authorizing PARENT or LEGAL GUARDIAN | Authorizing Signature of Parent or Legal Guardian | Date |