

**Abilene Physical Therapy and Sports Rehab
Patient Consent-Financial Obligation-Cancellation No-Show**

Initial on the line next to office policies and sign and date at the bottom

Consent For Treatment

I consent to evaluation and treatment procedures by Abilene Physical Therapy and Sports Rehab.

Release Of Information

I authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Abilene Physical Therapy & Sports Rehab to my physician(s), as well as any organization responsible for payment of any information by telephone or in writing for utilization & quality review purposes.

Assignment Of Insurance Benefits

I request that payment of authorized benefits be made directly to Abilene Physical Therapy and Sports Rehab for any services that are reimbursable by Medicare, Medicaid, or any other third party source.

Medicare

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize and holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers and such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

Guarantee of Account

_____ In consideration of services rendered to me by Abilene Physical Therapy & Sports Rehab, I hereby guarantee payment for any & all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance & for which I am fully responsible for paying. **It is ultimately my responsibility to understand my insurance benefit limitations and payments.** I will immediately notify Abilene Physical Therapy & Sports Rehab of changes in insurance coverage while receiving physical therapy.

Cancellation/No Show

_____ **There will be a \$15.00 charge for any No-Shows or Cancellations without 24 hour notice.** Any questions regarding this policy refer to front desk.

Open Clinic Care

_____ Abilene PT and Sports Rehab performs care and some evaluations in an open clinic. In some cases other people may hear discussions between you and your therapist during care. You have the right to request a private treatment room if you do not feel comfortable talking to your therapist in the main clinic. ***I am comfortable with open clinic environment for my care, should this change, I will let the physical therapist know ASAP.**

Privacy Practices

I acknowledge that a copy of Abilene Physical Therapy & Sports Rehab Privacy Practices was made available to me at the time of treatment. I know that I may ask for a copy of the Privacy Practices to take with me.

Signature

Date