CONSENT FOR TREATMENT
AND
FINANCIAL AGREEMENT

Patient Name: _____ **Date**: _____

CONSENT: I, the undersigned, do hereby agree and give my consent to Beck Physical Therapy, PC. to furnish Therapy Treatment.

RELEASE OF INFORMATION: I agree that the Facility may disclose my "protected health information" (PHI) in compliance with HIPPA Privacy Provisions, which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans and workers compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

CANCELLATION AND ATTENDANCE: I understand that good attendance is essential to receive the full benefit of Physical Therapy. I will make every effort to give 24 hours notice if I need to cancel an appointment. Three No Show appointments will result in discharge. If I am late for my appointment, I understand my therapist will have to modify my treatment plan in most cases.

FINANCIAL POLICY STATEMENT: As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payments at the time of service. If your insurance carrier does not remit payment within 60 days, 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. If any payments are made directly to you for services billed by us, you recognize an obligation to immediately remit same to Beck Physical Therapy, PC.

The above does not apply to those patients considered Workers' Compensation. However, be advised if you claim W/C benefits and are subsequently denied, such benefits you may be held responsible for 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, including Collections Fees, court costs and Reasonable attorney Fees.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

HIPPA PRIVACY NOTICE: I acknowledge that I have received the Facility's HIPPA Privacy Notice and have had the opportunity to review its content _____(Please initial).

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

_____ _____

Patient/Guardian/Responsible Party Date

_____ _____

Beck Physical Therapy Representative/Witness Date