BECK PHYSICALTHERAPY, P.C.

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 give physical therapy treatment.

CANCELLATIONS AND ATTENDANCE: I understand that good attendance is essential to receive the full benefit of physical therapy. I will make every effort to provide 24 hours' notice if I need to cancel an appointment. Three consecutive no shows will result in a discharge. If I am late for an appointment, I understand we may need to modify your treatment for physical therapy, or you may have to wait to be seen.

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 and co-payments/co-insurance (if applicable) at the time of service. If your insurance carrier does not remit payment, the balance will be due from you. 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. If your health plan determines a service to be "non-covered", you will be responsible for the complete charge and agree to pay the costs of all services provided. Estimated coverage information and copays is provided as a courtesy to our patients but is not intended to release them from total responsibility of their account balance.

The above does not apply to worker's compensation patients. However, be advised if your benefits are denied, you will be responsible for the charges for services rendered.

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 record to any third-party payers, including, but not limited to my health insurance company, lawyers, and worker's compensation carriers. This includes releases and disclosures of medical records in compliance with HIPPA when necessary for my treatment.

I UNDERSTAND MY PAYMENT RESPONSIBILITY ON MY ACCOUNT.

_____ _____

Patient/Guardian/Responsible Party Date

_____ _____

Beck Physical Therapy Representative Date