Consent for Outpatient Physical Therapy Treatment

Authorization

I hereby authorize the Physical Therapist of **Complete Rehabilitation & Sports P.T**. to provide medical care and administer all appropriate treatments allowable under the guise of the New York State Physical Therapy practice act and recommended by my physician(s) for purpose of treatment of my medical condition. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

Medicare Patients

I authorize any holder of medical information about me to release the Social Security Administration or its intermediaries or carriers any information needed for this or any related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment below. I also understand that it is my responsibility to obtain a new prescription from my doctor every 30 days from the date of the original prescription.

Please Initial X _____

Guarantee of Account

For and in consideration of services rendered to _____, by **Complete Rehabilitation & Sports P.T.**, I hereby agree to pay the full bill charges that are not covered or that are not paid to Complete Rehabilitation & Sports P.T. by Insurance or Worker's Compensation, or any balance due that is not covered by insurance or excluded by co-insurance clause. I understand that any payments directed to me by my insurance company for the intent of payment to Complete Rehabilitation & Sports Physical therapy, must be forwarded directly to Complete Rehabilitation & Sports Physical Therapy by me.

Cancelation /No Show Policy

It is very important to arrive promptly for your scheduled appointment. In the event that you need to cancel or reschedule an appointment please give us notice. **If you fail to keep your appointment (No Show) you will be charged a fee of $25.00.**

I understand that I have a $_____ co-payment/payment for each office visit, including the Evaluation appointment. These payments are expected at the time of every visit. When you have Co-ins we will agree on an amount per visit and adjust the account when final payment from insurance is received.

Please note: Failure to report any changes in your insurance coverage could make all services your responsibility.

Release of information

I permit **Complete Rehabilitation & Sports P.T.** to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for collection of benefits or payment of charges.

Assignment of Benefits

I assign Complete **Rehabilitation & Sports Physical Therapy** all benefits from any corporation /Insurance Company, agency and/or person for the services rendered. I authorize payment directly to **Complete Rehabilitation & and Sports P.T**.

I confirm that I have read and fully understand the above statements.

Patient Signature: X _____Date:_____

Relative or Guardian (if pt is under 18) Print Name: _____