ADVANCED PHYSICAL THERAPY OF VIRGINIA

Consent Form

Patient Name: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent to Advanced Physical Therapy and all its health care professionals using its facility to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her condition. These interventions are in accordance with the State Practice Act for their respective professions.

Patient/Guardian/Responsible Party Signature _____ **Date** _____

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and third party payers to Advanced Physical Therapy. I also request assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party Signature _____ **Date** _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. 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. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If payment is made directly to you for services billed by us, you are required to promptly submit the same to Advanced Physical Therapy.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will 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 60 days, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, attorney fees and **FINANCE CHARGES**. There will be a $30.00 charge for each check returned from the bank.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

I have also received a copy of the "NOTICE OF PRIVACY PRACTICES."

Patient/Guardian/Responsible Party Signature _____ **Date** _____

Facility Representative / Witness Signature _____ **Date** _____