Apex Physical Therapy

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for APEX Physical Therapy to furnish medical care and treatment to ______________________ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian______________________ Date________________________

Benefit Assignment Release of Information

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to APEX Physical Therapy.
A photocopy of this 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____________________ Date __________________________

Financial Policy Statement

We bill your insurance carrier solely 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 45 days, the balance will be due in full from you. In the event that your insurance carrier 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 any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to APEX Physical Therapy.

The above does not apply for those patients that are an HMO plan of considered Worker's 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 rendered to you.

When you pay by check, you expressly authorize APEX Physical Therapy, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please Note: The above language authorizes an electronic debit to your account for the state allowed debit fee. In accordance with the rule of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that APEX Physical Therapy can not collect a return check fee by other methods.

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 owed, including court costs, collection agency fees and attorney fees.

According to the information we received from your insurance company you have a deductible of_____________
Co-pay/Co ins. of ______________ however, this is not a guarantee of information by your insurance company.

The above information has been explained to me. I UNDERSTAND MY RESPONSIBILTY FOR THE PAYMENT OF THE ACCOUNT.

______________________________________ ______________________________

Patient/Guardian/Responsible Party Date

______________________________________ ______________________________

Center Representative/Witness Date