



PATIENT CONSENT

CONSENT FOR TREATMENT: I hereby authorize the performance of any medical procedure, which may be advised and/or recommended by my physical therapist and/or physician.

AUTHORIZATION FOR INSURANCE PAYMENT AND RELEASE OF MEDICAL INFORMATION: I authorize the release of any medical or other information necessary to process my claims. I also request payment for my medical services to be paid directly to Ford Physical Therapy for any services provided.

AUTHORIZATION FOR VERIFICATION OF EMPLOYMENT: I hereby, by my signature at the bottom of this form, give Ford Physical Therapy permission to verify my employment to assist in collection of my unpaid bill and/or for insurance verification purposes.

FINANCIAL POLICY: We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility. All patients must complete our "**Patient Information Form**" before receiving treatment.

I understand that I will be responsible for all charges incurred during my course of treatment in this office, regardless of insurance coverage.

INSURANCE: If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you will be responsible for your estimated co-Insurance amount and any unmet deductible amount at the time of service; however, if your insurance company pays more than the balance due, we will send a refund check to you.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We file insurance claims as a COURTESY to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual, customary, & reasonable" charges, etc., other than to supply factual information as necessary. **You are responsible for the timely payment of your account.**

ACCOUNT POLICY: Our policy is that after your insurance company has processed all dates of service, we expect any remaining balance on your account to be paid within 60 days. Any past due account may be turned over to a collection agency or pursued in small claims court for collection. At that time, you may be responsible for the balance on your account, plus up to a 33.3% collection agency fee and/or court costs. Therefore, please do not let your account reach this point without trying to make satisfactory arrangements with us to keep your account current.

MEDICARE-MEDICAID-TRICARE-WORKER'S COMPENSATION: If you are covered by any of these types of insurance or any other government sponsored program, please discuss your payment situation with our office staff.

WORKER'S COMPENSATION PATIENTS: I authorize the release of all my medical information to my Employer, Insurance Adjuster and/or any Case Manager assigned to my worker's compensation claim. I further understand that if I am non-compliant with my treatment program and/or appointments you may notify my Employer, Insurance Adjuster, Case Manager and/or Referring Physician.

CANCELLATIONS and NO SHOWS: If you cannot make your appointment, please call the day before to cancel. Cancellations the day of a scheduled appointment or a no show will be charged a \$25.00 fee.

Patients/Guardian Signature _____ Date _____

Witness _____

We accept CASH or CHECKS only.

If patient is a minor, please give responsible party's name. Responsible Party _____