PHYSICAL THERAPY SOLUTIONS INC

Orthopedic, Neurological & Vestibular Rehabilitation Consultants *Your Health, Our Hands*

CONSENT FOR TREATMENT, ASSIGNMENT AND RELESE OF INFORMATION FOR PAYMENT

PATIENT'S NAME _____

CONSENT FOR TREATMENT

I voluntarily agree and give my consent for staff and personnel at Physical Therapy Solutions Inc. to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I hereby assign to Physical Therapy Solutions Inc. payment of medical reimbursement benefits under my/ any other insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. A photocopy of this assignment is to be considered as valid as the original. I here by authorize said assignee to release all information necessary, including medical records, to secure payments.

I understand that I am financially responsible for all charges whether or not they are covered by my insurance as well as any co-payment and co-insurance. In the event of non-payment for any of these costs, I understand I will be legally responsible for all the costs involved with the collection of this account including all the court costs, reasonable attorney fees and any expenses incurred should this be required.

CANCELLATION POLICY

Together, you and your therapist will set your treatment goals and time frame to complete these goals. It is important that you attend all scheduled treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions to achieve the best success. If you must cancel or change an appointment, we request that you notify our office a minimum of 24 hours prior to your scheduled appointment time by calling (847) 240-2000. If you are a worker's compensation patient, please be advised that your employer, physician and rehabilitation nurse will be notified of each missed appointment.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices of Physical therapy Solutions Inc.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION. INITIAL_____

I ACKNOWLEDGE THAT I HAVE READ THIS CONSENT FORM AND HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS.

_____ _____ _____ _____

Patient or Legal Representative's Signature Patient's Printed Name Date

_____

Guarantor and/or insured Person's Signature (if other than patient)

Office Use Only: _____ _____

Witness Date

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