Pro-Motion Physical Therapy

PATIENT CONSENT FORM

I HEREBY AUTHORIZE PRO-MOTION PHYSICAL THERAPY, INC. TO FURNISH PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY TREATMENTS AS INDICATED BY MY REFERRING PHYSICIAN.

I AUTHORIZE PRO-MOTION PHYSICAL THERAPY, INC. TO RELEASE ANY MEDICAL OR OTHER INFORMATION THAT MAY BE NECESSARY TO PROCESS MEDICAL CLAIMS ON MY BEHALF TO RELATED PHYSICIANS AND INSURANCE CARRIERS, WITH ADDITIONAL WRITTEN AUTHORIZATION TO ATTORNEYS, SOCIAL WORKERS AND REHABILITATION COUNSELORS.

I AUTHORIZE PRO-MOTION PHYSICAL THERAPY, INC. TO INITIATE A COMPLIANT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING MY CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT I AM **RESPONSIBLE** FOR ANY BALANCE DUE AFTER PAYMENT BY MY INSURANCE COMPANY.

I, THE UNDERSIGNED, UNDERSTAND THAT PRO-MOTION PHYSICAL THERAPY, INC WILL BILL MY INSURANCE CARRIER FOR SERVICES RENDERED UPON VERIFICATION OF MY COVERAGE BY INSURANCE COMPANY**. IF MY INSURANCE COMPANY FAILS TO RENDER PAYMENT FOR SERVICES RENDERED, I HEREBY PERSONALLY GUARANTEE PAYMENT FOR MEDICAL CARE AND SERVICES RENDERED.** IF MY INSURANCE COMPANY DOES NOT REMIT PAYMENT WITHIN 60 DAYS, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE BALANCE DUE IN FULL.

I HEREBY REQUEST THAT MY INSURANCE CARRIER MAKE PAYMENT DIRECTLY TO PRO-MOTION PHYSICAL THERAPY, INC. FOR ALL SERVICES RENDERED. IF MY CURRENT POLICY. PROHIBITS DIRECT PAYMENT; TO PRO-MOTION PHYSICAL THERAPY, INC. I HEREBY INSTRUCT AND DIRECT MY INSURANCE CARRIER TO MAKE THE CHECK OUT IN MY NAME, BUT SEND THE CHECK TO PRO-MOTION PHYSICAL THERAPY, INC.

IF MY INSURANCE CARRIER MAKES PAYMENT TO ME, I AGREE TO **IMMEDIATELY** PAY OVER THESE FUNDS TO PRO-MOTION PHYSICAL THERAPY, INC. I ALSO AUTHORIZE PRO-MOTION PHYSICAL THERAPY, INC TO DEPOSIT CHECKS RECEIVED ON MY ACCOUNT WHEN MADE OUT TO ME.

I UNDERSTAND AND AGREE THAT IF I FAIL TO MAKE ANY OF MY PAYMENTS FOR WHICH I AM RESPONSIBLE IN A TIMELY MANNER, I WILL BE RESPONSIBLE FOR ALL COSTS OF COLLECTING MONIES OWNED, INCLUDING COURT COSTS, COLLECTION AGENCY FEES, AND ATTORNEY FEES.

CHARGES RELATED TO WORKERS COMPENSATION INJURY SHALL BE FORWARDED TO THE WORKERS COMPENSATION INS.CARRIER AND I WILL NOT BE HELD PERSONALLY RESPONSIBLE FOR THESE CHARGES. 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 FOR SERVICES RENDERED TO YOU.

YOUR HEALTH INSURANCE CARRIER HAS VERIFIED THAT YOU HAVE A $_____YEARLY DEDUCTIBLE OF WHICH $_____ HAS BEEN MET. AFTER YOUR DEDUCTIBLE HAS BEEN SATISFIED, YOUR INSURANCE CARRIER COVERS THERAPEUTIC BENEFITS AT _____%. YOU HAVE A RESPONSIBILITY OF _____% OR $ _____ CO-PAYMENT PER VISIT. YOUR INSURANCE COMPANY HAS ADVISED US THAT YOUR POLICY HAS THE FOLLOWING LIMITATIONS:

IN ORDER TO ENSURE THAT WE ARE FILING THE CORRECT INSURANCE PLEASE ANSWER THE FOLLOWING QUESTIONS:

IS THIS INJURY RELATED TO AN AUTO ACCIDENT?: ❑ **YES** ❑ **NO**
IS THIS INJURY RELATED TO A WORKERS COMPENSATION INJURY?: ❑ **YES** ❑ **NO**

BENEFITS THAT WE HAVE RECEIVED FROM YOUR INSURANCE CARRIER AT THE TIME OF SERVICES ARE NOT A GUARANTEE OF PAYMENT. THE PATIENT, LEGAL GUARDIAN, OR PARENT (IF CHILD IS UNDER 18 YRS OF AGE) WILL BE RESPONSIBLE FOR THE COPAYMENT AT THE TIME OF SERVICES.

_____
PATIENT/GUARDIAN DATE

_____
RELATIONSHIP TO PATIENT DATE

_____
WITNESS DATE