ENCHANTED LAKE PHYSICAL THERAPY

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned do hereby agree and give my consent for **Enchanted Lake Physical Therapy** and/or its affiliates to provide physical therapy care and treatment considered necessary and proper in evaluation or treating my physical condition. _____ (initial)

CONSENT FOR CARE & TREATMENT OF A MINOR: As a parent and/or legal guardian of _____ , (patient's name) I understand that a Physical Therapist will complete an evaluation by examination and interview. An individual treatment program will then by designed. A variety of treatment techniques may be used. I, the undersigned do hereby agree and give my consent for **Enchanted Lake Physical Therapy** and/or its affiliates to provide physical therapy care and treatment considered necessary and proper in evaluating or treating the minor listed above while I am not present. _____ (initial)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Enchanted Lake Physical Therapy** or its legal representative, to release information to insurance carriers concerning this treatment and I hereby assign all payment services rendered. _____ (initial)

ASSIGNMENT OF MEDICARE BENEFITS & RELEASE OF INFORMATION: By signing below, I request that payment of authorized Medicare benefits be made on my behalf to: **Enchanted Lake Physical Therapy** for any services furnished me. I authorize holder of medical information about me, to release to the Centers for Medicare Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. _____ (initial)

ASSIGNMENT OF SECONDARY INSURANCE BENEFITS (Medigap) & RELEASE OF INFORMATION: By signing below, I request that payment of authorized Medigap benefits be made on my behalf to **Enchanted Lake Physical Therapy** for any services furnished to me by this provider. I authorized any holder of medical information to release to: _____ (name of secondary insurer) any information needed to determine these benefits or the benefits payable for related services. _____ (initial)

WORKER'S COMPENSATION CLAIMS: If you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. _____ (initial)

FINANCIAL POLICY: We will bill your personal insurance carrier solely as a courtesy to you. We require that arrangements for payment of your estimated share of cost be made. You are responsible for all charges whether or not paid by said insurance. These include deductibles, co-payments, cost-share, and/or non-covered benefits. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. In the event of default, you shall be responsible for all costs of collection and reasonable attorney fees. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you and you agree to pay your portion of this bill. We assume no liability for any errors made by your insurance carrier in this quotation. _____ (initial)

Estimated patient payment may include: co-pays, co-insurance and or deductibles. I agree to pay: $ _____ at the time of each visit.

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

_____ _____ _____

Patient/Parent/Guardian Signature Relationship to Patient Date