Consent for Treatment and Statement of Financial Responsibility

CONSENT FOR TREATMENT: I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.

RESPONSIBLITY FOR PAYMENT: All co-payments are due at the time of services. I acknowledge that in consideration of the services provided to me by Springer Physical Therapy, LLC, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Springer Physical Therapy, LLC with current insurance information and to familiarize myself with my insurance plan and policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-pay, co-insurance, or charges not covered or denied by my health insurance, Medicare, or other Payers for which I am eligible Springer Physical Therapy, LLC., will charge a minimum of $30 for any payment that is returned as non-sufficient funds (NSF). This includes checks and all forms of electronic payments. When the payment is returned from the bank as NSF, Springer Physical Therapy, LLC., will add such charges to the amount owed by the payor.
I agree to within five (5) days of demand by Springer Physical Therapy, LLC to pay or reimburse Springer Physical Therapy for reasonable costs and expenses of collection of my overdue or unpaid amounts, including collection agency fees, attorney's fees, arbitration fees, arbitration costs, and court costs, whether or not a lawsuit is filed.

ASSIGNMENT OF BENTFITS: I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitled, to Springer Physical Therapy, LLC. A Photocopy of this assignment is to be considered as valid as original. I hereby authorize the release of all information necessary, including Medical Records, to secure payment.

APPOINTMENT AGREEMENT: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that *I may be rescheduled if I arrive more than 15 minutes late for my appointment*. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given for one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment.

WORKERS COMPENSATION PATIENTS: *We appreciate your full cooperation in attending all scheduled therapy visits. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or cancelled appointments. It is also required that all missed visits be rescheduled.*

ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Springer Physical Therapy, LLC may document medical and other information related to my treatment in electronic and other forms and that such information will be used during my treatment for payment purposes and to assist those who are treating me. I authorize my clinician(s) and Springer Physical Therapy, LLC, Administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Springer Physical Therapy, LLC Notice of Privacy Practices, that it outlines how my health information will be used and disclosed, and how I may gain access to and control my health information.

HIPAA CONSENT: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account. I also authorize the release of appointment information left in voicemail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

NAME/RELATIONSHIP_____ **NAME/RELATIONSHIP**_____

PATIENT IDENTITY: My Signature below means that I have given truthful information about my name and identity. It also means that I understand, how important it is to provide truthful information about my condition. That incorrect or false information about my condition can lead to treatment that could harm the patient. That Springer Physical Therapy, LLC, reserves the right to take action for intentional presentation of false information including transfer of care and appropriate reporting to authorities.

Signature of Patient/Legally Responsible Person_____ **Date**_____

Printed Name of above _____**Date**_____

Springer Physical Therapy, LLC complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.