CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for First Choice Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party _____ Date_____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a ***courtesy*** to you. You are responsible for the entire bill when services are rendered. We require that arrangement for payment of your estimated portion be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same payment to First Choice Physical Therapy.

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

First Choice Physical Therapy verifies benefits as a ***courtesy*** to you. However, First Choice Physical Therapy does NOT accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

If payment is made by check and the check comes back as NSF (non sufficient funds) you are then responsible to pay us the amount of the check plus a $30.00 returned check fee. From that point forward you will be required to pay by cash or credit card.

I understand and agree that if I fail to pay any of the payments for which I am responsible within 45 days, my balance due will be pursued by collections.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient/Guardian/Responsible Party **Date**

_____ _____

Center Representative/Witness **Date**