CONSENT FOR TREATMENT

CONSENT FOR TREATMENT OF PATIENT or A MINOR: As parent and/or legal guardian, I authorize **BioSport Physical Therapy** to treat the minor patient named in the attached forms while I am not present.

CONSENT FOR CARE & TREATMENT: Your Physical/Occupational Therapist will complete an evaluation by interview and examination. 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 **BioSport Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **BioSport Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for service rendered to **BioSport Physical Therapy**.

WORKER'S COMPENSATION CLAIMS: If you claim workers compensation and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

RETURNED CHECKS: Our office charges **$25** for all checks returned to your bank

RECORDS COPY FEE: Our records are automatically sent to the physician who referred you here. If you need your records for any other reason, there is a **$15** fee if we copy them or $15 fee if you or your lawyer sends a copy service.

CANCELLATIONS & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. Regarding cancellations without proper notice (24 hours): patients will be given a warning on the 1st occurrence, will incur a **$35** out-of-pocket charge on the 2nd occurrence, and discharged from therapy on the 3rd occurrence. We do realize and understand there are special circumstances which will be considered but we strongly discouraged no-shows.

The above information has been read.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient / Guardian / Responsible Party DATE

FINANCIAL POLICY

CANCELLATIONS & NO-SHOW POLICY: We require 24 hours' notice in the event of a cancellation. Regarding cancellations without proper notice (24 hours): patients will be given a warning on the 1st occurrence, will incur a $35 out-of-pocket charge on the 2nd occurrence, and discharged from therapy on the 3rd occurrence. We do realize and understand there are special circumstances which will be considered but we strongly discouraged no-shows. **Initial that you understand:** _____

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 (sixty) 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 the insurance company makes any payment directly to you for services billed by us, you recognized an obligation to promptly remit the payment(s) to us. If formal collection procedures become necessary, you will be responsible for additional cost incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this question. We have reviewed these benefits with you, and you agree to pay your portion of this bill.

Estimated patient payment / co-pay / deductible amount per visit $/%_____

Arrangements for payment of patient's co-pay/deductible (**circle one**)

WILL PAY EACH VISIT **WILL PAY WEEKLY IN ADVANCE**

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

_____ _____

Patient / Guardian / Responsible Party DATE

_____ _____

BioSport Representative DATE