ASSIGNMENT BY RESPONSIBLE PARTY/FILE SIGNATURE

In consideration of the medical care provided to the patient named below, I assign to Wadsworth Family Physical Therapy, Inc. the right to any medical insurance benefits to which I am or may be entitled by any health plan. ***We call on insurance benefits as a courtesy to you, but it is your responsibility to know your benefits.** This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original.

Initial *_____

PATIENT CONSENT FORM

I hereby authorize Wadsworth Family Physical Therapy, Inc. and any of their representatives to provide physical therapy to myself or to any minor (under age 18) that I represent. I understand that by signing this form I am, or the minor I represent, consenting to treatment.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand by signing this form I am authorizing Wadsworth Family Physical Therapy, Inc. to release any and all pertinent information regarding my physical therapy to my Doctor, Insurance Co., Attorney, etc.

PAYMENT POLICY

Most insurance companies and Medicare will only pay a maximum of 80 percent of physical therapy charges. I understand that I am responsible for any balance after my insurance considers their liability. I understand that it is my responsibility to check if physical therapy is a covered item in my medical insurance plan. I also understand that I am responsible for any referrals and any limitations (number of visits) that my insurance plan may have. I agree fully and personally to be responsible for any payments that my medical insurance does not make. I understand interest and or legal fees will be added to my balance and will also be my responsibility.

I AM AWARE THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL. Remember.....every insurance is different.... it is YOUR responsibly to know your health insurance benefits.

_____

Patient's name

_____ Date _____

Patient's signature (or guardian's signature if patient is a minor)

ACKNOWLEGMENT OF RECEIPT

I acknowledge that I have received the Notice of Privacy Practices issued by Wadsworth Family Physical Therapy, Inc.

I authorize Wadsworth Family Physical Therapy, Inc. to discuss my health information with the following persons:

Spouse _____
Children _____
_____
Parent _____
_____
Other _____
_____

_____ _____

Date Signature of Patient

Rev. 10/05/2016 RH