**CONSENT FOR CARE AND 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 **SPU Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

**CONSENT FOR RELEASE OF MEDICAL RECORDS:** I hereby authorize my referring physician to release any of my pertinent medical information to **SPU Therapy** for use in the evaluation of my condition and the design of my individual treatment program.

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

**WORKER’S COMPENSATION CLAIMS:** If you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

**CANCELLATION AND NO-SHOW POLICY:** If you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance. We will make every attempt to reschedule your appointment. If you miss your appointment without calling in advance, you will be charged a $25.00 no-show fee. This payment takes effect on your second missed appointment without previous notice. If cancellations or no-shows become excessive (3 maximum), we will remove you form the schedule and ask you to call us the morning of the day you wish to be seen. We will fit you into the schedule as close as possible to the time you request. All cancellations no-shows and tardiness are documented in your medical record. Case managers and referring physicians for worker’s compensation patients are notified after each missed appointment. All workmen’s compensation patients with excessive missed appointments (3 maximum) will be removed from the schedule and the case manager and physician will be notified. The case manager must notify us before further appointments can be made. Initials\_\_\_\_\_\_\_\_

**FINANCIAL POLICY:** We will bill your personal insurance carrier solely as a courtesy to you. You are ultimately responsible for your bill. 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. If formal collection procedures become necessary, you will be responsible for any additional costs incurred.

**PATIENT PAYMENT / COINSURANCE / DEDUCTIBLE: SPU Therapy** will bill patient or guarantor for any charges that are the patient’s responsibility after receipt of the insurance company’s explanation of benefits (EOB). The EOB will reflect what charges are the patient’s responsibilities and our billing will correspond to these amounts. All accounts are net 30 days from date of invoice.

**PATIENT COPAY:** Copays must be paid prior to the start of treatment.

The above information has been explained to me.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_