

**CONSENT FOR CARE AND TREATMENT:**

I, the undersigned, do hereby agree and give my consent to Edgewater Physical Therapy to provide medical care and treatment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_considered necessary and proper in diagnosing or treating my physical condition.

Patient/guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BENEFIT ASSIGNMENT/RELEASE OF INFORMATION:**

I authorize Edgewater Physical Therapy to release to my insurance company any medical information necessary to process claims for treatment that I receive under their care in order to secure payment. I authorize payment of any insurance benefits for physical therapy services be paid directly to Edgewater Physical Therapy.

Patient/guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY/NOTIFICATION OF PATIENT RESPONSIBILTY:**

Edgewater Physical Therapy will bill your insurance carrier. We have verified your Physical Therapy benefits with your insurance company based on the information provided by you. Please be advised that your insurance company has the disclaimer that this is a verification of benefits only, and not a guarantee of payment. Benefits/payments are determined once the claim is received. We do not accept responsibility for the accuracy of the information provided by your insurance company. We recommend that you contact your insurance company directly if you have any questions or concerns regarding your benefits.

Co-pay$\_\_\_\_\_\_\_\_\_\_\_\_/visit or co-insurance\_\_\_\_\_\_\_\_\_\_%/visit=approximately\_\_\_\_\_\_\_\_\_\_\_\_/visit

Deductible amount$\_\_\_\_\_\_\_\_\_\_\_\_ deductible met$\_\_\_\_\_\_\_\_\_\_\_ visit limit\_\_\_\_\_\_\_\_\_\_\_\_\_

Other benefit information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NO SHOW/NO CALL POLICY:** Edgewater Physical Therapy charges **$50** for a missed appointment when no prior notice is given. Please make every attempt to notify us if you need to cancel or reschedule an appointment.

Please verify that you understand your financial responsibility by signing and dating this form.

Patient/guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_