Consent for Care & Treatment

I, _____, hereby give my consent to Revive Physical Therapy, Inc. to furnish physical therapy as considered necessary and proper for evaluation and treatment.

Benefit Assignment and Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare and contracted Private Insurances to Revive Physical Therapy, Inc. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Revive Physical Therapy to release all information necessary, including medical records to secure payment.

Information Policy: Revive Physical Therapy Inc. will use and disclose your personal health information to treat you, to receive payment for the care provided to you and for other health care operations. Health care operations include but not limited to those activities we perform to improve the quality of care. We have a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always have copies of the current notice for distribution at our facility.

Designated Individuals

I hereby authorize the following parties to receive any protected health information regarding treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of these parties must be verified before the release of any information. I also understand that these parties may be contacted in case of emergency.

Name: _____ Phone: _____

Name: _____ Phone: _____

Financial Policy Statement

WE BILL YOUR INSURANCE CARRIER SOLELY AS A COURTESY TO YOU, IF YOUR INSURANCE DENIES PAYMENT FOR ANY REASON, YOU MAY BE RESPONSIBLE FOR THE ENTIRE BILL. You will be responsible for all co-payments, co-insurance percentage, and/or unmet deductibles at the time of services are rendered. In the event your insurance carrier requests a refund of payments made for any reason, you will be responsible for total monies refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly submit payment to Revive Physical Therapy, Inc.

ESTIMATED INSURANCE BENEFITS AND PATIENT RESPONSIBILITY:

_____

_____

Late / No Show Policy

We ask that you please call within 24 hrs to cancel or reschedule appointments. If you are more that 15 min late you may be asked to reschedule.

I have read and understand the above information and understand that all claims final determination and approval is at the discretion of my insurance carrier, and that I am responsible for any amount left to patient responsibility once a claim has been reviewed and processed through my carrier.

I understand and agree that if I fail to make any payments for which I am responsible in a timely manner, I will be responsible for the cost of collection of all monies owed, including but not limited to: court cost, collection agency fees, and attorney fees.

When paying by check I acknowledge and accept that if my check is dishonored or returned for any reason, I will be responsible for all bank fees, and the full amount of the returned check along with a reprocessing fee of $25.00.

By signing below, I agree to all the above, give consent for care and treatment, and claims filing to my insurance carrier on my behalf.

Patient and/or Legal Guardian Signature:

_____

Today's Date: _____ Office Witness: _____

Patient Intake Form

Full Name _____
Last Middle First

Mailing Address _____

City _____ State_____ Zip Code _____

Phone _____
Cell Home

DOB _____ Social Security No. _____

Email _____

How did you Hear about Us ? Please Circle One

Google **Word of Mouth** **My Doctor** **My Insurance** **I Saw the Sign**

Family Physician _____ Referring Physician_____

Emergency Contact _____
Name Phone #

Primary Insurance _____
Name **ID #** **Group #**